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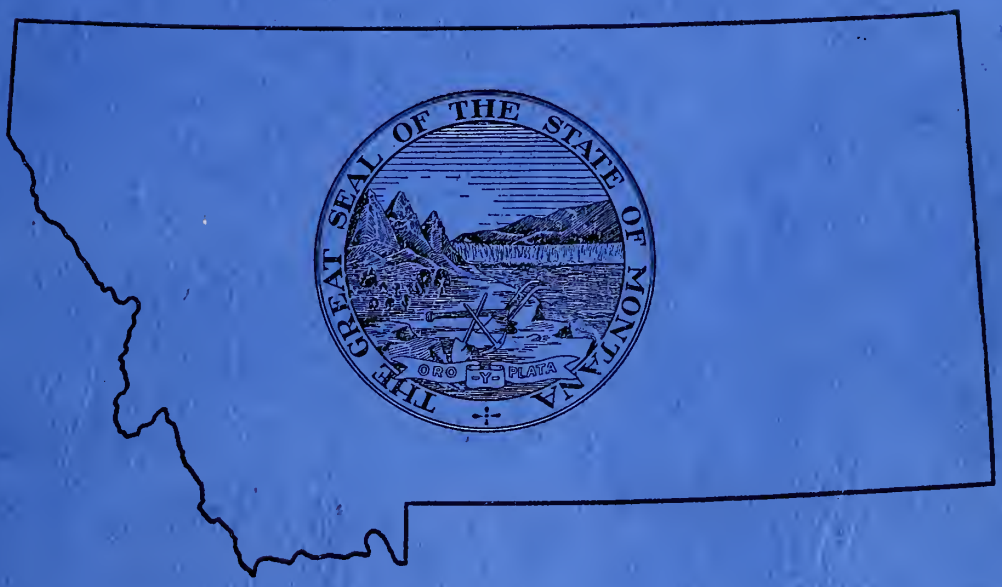


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# A M O N T A N A

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# S E R V I C E S

PREPARED BY

STATEWIDE AND COMMUNITY MENTAL HEALTH PLANNING COMMITTEE

JUNE 30, 1965

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LETTER OF TRANSMITTAL

June 30, 1965

TO: The Citizens of Montana through the Mental Health Authority of the State of Montana

Central to the thinking of all the members of Montana's Mental Health Planning Committee has not only been how best to implement in the State a program of community based mental health services, but also, proposals which would complement and utilize already existing facilities. In fact the plan as it evolves takes account of and reinforces the work now being done by the hospital at Warm Springs and the five mental hygiene clinics located in the State of Montana.

The work of the Planning Committee on mental health began its task with a factual study of contributing elements having either a positive or negative effect on the overall problem of mental health among the people of Montana. This led to a critical analysis of these elements as to their particular role, and subsequently evolved this plan which makes recommendations for the implementation of a more effectual program.

One fact of which the Committee has been most aware is the changing emphasis in the care and treatment of the mentally ill. Not only are patients treated more economically in community based facilities close to their home and families but they can be restored to

sound mental health in a shorter period of time with less therapy. The community based mental health program provides the means for early detection and prevention of mental disorders. Treatment in the community setting provides for the preservation of the dignity of those being treated and minimizes the adjustment necessary to function in society.

Our plan recognizes that a change in philosophy is meaningless if ways are not provided for the implementation of this philosophy into a positive program. We of the Committee are confident that when the people of Montana have possession of the facts herein presented, their response will provide sufficient resource to implement this plan into a meaningful program looking toward the prevention of the blight of mental illness from our society.

Ours has been a time consuming and hard task but it has been a rewarding one. We are grateful for the dedication and competence of the project staff which has made the work of the Planning Committee such a pleasant experience and revelation.

It is with humble satisfaction and with the conviction that a significant milestone has been written in the history of the State of Montana and with deep gratitude to all those who have so freely given of their time and talent that this plan is submitted to and for the people of the State of Montana.

Very respectfully submitted,

John S. W. Fargher

John S. W. Fargher, D.D., Chairman
Montana Mental Health Planning Committee

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CHAPTER I

# INTRODUCTION

## MENTAL HEALTH PLANNING

Social survey studies have been known for over 100 years. These studies have been done on crime, suicide, land values, residential structures, psychoses, and other topics. In its 1961 report, the Surgeon General's Ad Hoc Committee on Planning for Mental Health Facilities recommended "that the Governors of each state consider taking whatever steps are necessary to stimulate the development of a comprehensive plan for mental health facilities".[1]

The late President John F. Kennedy's message to Congress on February 5, 1963 brought forcibly to Congress and the nation the importance of planning as the first step in meeting the needs of citizens suffering with mental illness or mental retardation. The following excerpts from this address reveal the intent and focus of the message and the action contemplated by it.[2]

> It is my intention to send shortly to the Congress a message pertaining to this nation's most urgent needs in the area of health improvement. But two health problems - because they are of such critical size and tragic impact, and because their susceptibility to public action is so much greater than the attention they have received - are deserving of a wholly new national approach and a separate message to the Congress. These twin problems are mental illness and mental retardation.
>
> . . .
>
> Governments at every level - Federal, State and Local - private foundations and individual citizens must all

[1] U.S., Department of Health, Education and Welfare, Planning of Facilities for Mental Health (Public Health Service Publication No. 808), p. 3.

[2] U.S., Congressional Record, 88th Cong., 1st Sess., 1963, CIX, Part 2, 1837.

face up to their responsibilities in this area. Our attack must be focused on three major objectives: First, we must seek out the causes of mental illness and of mental retardation and eradicate them.

. . .

Second, we must strengthen the underlying resources of knowledge and, above all, of skilled manpower which are necessary to mount and sustain our attack on mental disability for many years to come.

. . .

We must increase our existing training programs and launch new ones.

. . .

Third, we must strengthen and improve the programs and facilities serving the mentally ill and the mentally retarded. The emphasis should be upon timely and intensive diagnosis, treatment, training and rehabilitation so that the mentally afflicted can be cured or their functions restored to the extent possible. Services to both the mentally ill and to the mentally retarded must be community based and provide a range of services to meet community needs.

It is with these objectives in mind that I am proposing a new approach to mental illness and to mental retardation. This approach is designed, in large measure, to use Federal resources to stimulate state, local and private action.

. . .

We need a new type of health facility, one which will return mental health care to the main stream of American medicine, and at the same time upgrade mental health services. I recommend, therefore, that the Congress (1) authorize grants to the States for the construction of comprehensive mental health centers, beginning in fiscal year 1965, with the Federal Government providing 45 to 75 percent of the project cost; (2) authorize short-term project grants for the initial staffing costs of comprehensive community mental health centers, with the Government providing up to 75 percent of the cost in the early months, on a gradually declining basis, terminating such support for a project within slightly over four years; and (3) to facilitate the preparation of community plans for these new facilities as a necessary preliminary to any construction or staffing assistance, appropriate $4.2 million for planning grants under the National Institute of Mental Health.

We as a nation have long neglected the mentally ill and the mentally retarded. This neglect must end, if our

nation is to live up to its own standards of compassion and dignity and achieve the maximum use of its manpower. This tradition of neglect must be replaced by forceful and far-reaching programs carried out at all levels of government, by private individuals and by State and local agencies in every part of the Union. We must act --

to bestow the full benefits of our society on those who suffer from mental disabilities;
to prevent the occurrence of mental illness and mental retardation wherever and whenever possible;
to provide for early diagnosis and continuous and comprehensive care, in the community, of those suffering from these disorders;
to stimulate improvements in the level of care given the mentally disabled in our state and private institutions, and to reorient those programs to a community-centered approach;
to reduce, over a number of years, and by hundreds of thousands, the persons confined to these institutions;
to retain in and return to the community the mentally ill and mentally retarded, and there to restore and revitalize their lives through better health programs and strengthened educational and rehabilitation services; and
to reinforce the will and capacity of our communities to meet these problems, in order that the communities, in turn, can reinforce the will and capacity of individuals and individual facilies.

The 88th Session of Congress established a grant-in-aid for conducting mental health surveys in each of the 50 states and three territories. To make possible a comprehensive study in Montana, the state mental health authority was directed by the Governor of Montana to submit a plan for utilization of federal planning grant monies. Montana was authorized a grant of $50,000.00 for each of the fiscal years 1964 and 1965. The Montana Project for Mental Health Planning officially began on December 1, 1963 following receipt of final approval of the state plan by the National Institute of Mental Health. The Project's funds terminate as of June 30, 1965 and planning as it involves the paid professional staff will therefore

cease on that date; however, it is the desire of the Planning Committee to continue as an ongoing, functioning part of planning for better mental health services in Montana.

Social surveys are essential to any planning for the prevention, treatment and care of the mentally ill. Knowledge of the age-adjusted rates[1] within the several areas studied will enhance the ability of a mental health authority to direct a program to specific areas of need. Likewise the information obtained from this kind of research will help a mental health authority in planning a comprehensive program for the mental health needs of this state on a long-range basis. Furthermore, effective planning will mean better use of monies appropriated for the development and administration of mental health programs.

## NEED FOR PLANNING IN MONTANA

The late President's message stressed the need for a comprehensive plan in coping with the problems of mental health and retardation. A meaningful statement as to the need for planning was made by Warren H. Dunham, prominent sociologist: "Data as to distribution of mental disorders in time and space, with accompanying variations in age, sex, nationality, race and economic condition are essential as basic data in any mental hygiene program".[2]

---

[1] One of the most common statistical procedures used in deriving reliable and comparable measures of social conditions for the entire population of several areas is to compute adjusted rates. By this statistical method, it is possible to obtain comparable rates regardless of differences in the composition of the population.

[2] Warren H. Dunham, "Ecological Studies of Mental Disorders: Their Significance for Mental Hygiene", Mental Hygiene, XXIV, (April 1940), p. 246.

Historically, Montana, like most states, has not had a projected plan to meet even the most pressing problems caused by mental illness. The movement from crisis to crisis has been marked by building programs and appropriations of funds for operations to meet the cumulative pressures of the time with little, if any, thought of future needs or different, more realistic goals. Crisis legislation based on urgency, rather than planned programs based on factual, substantiated information, has been the pattern. The pressures of treating the problems of mental illness has resulted in failure to give even token attention to prevention. Montana, like many other states, must develop a program that will emphasize assistance for the individual to help prevent his being relegated to an institutional setting. It has been shown in many states with advanced programs that early treatment in the community can be invaluable in maintaining a disturbed personality at a level of social functioning.

Montana's 1963 Legislative Assembly cast aside partisan politics and established a State Department of Public Institutions. The stated purpose of the legislation was "to utilize at maximum efficiency the resources of state government in a coordinated effort to restore the physically or mentally disabled . . . . . ". The value of this reorganization cannot yet be assessed. The Department will need time to develop its full potential. However, as a result of the present comprehensive mental health survey plan, Montana will have available for the first time in its history research upon which future decisions can be based in the development of comprehensive mental health programs.

## ORGANIZATION OF PLANNING

With the appointment of a planning committee representing many disciplines interested in mental health, the process of creating a plan was begun. The Planning Committee, originally composed of 32 delegates, met and selected from its ranks a steering committee composed of 12 members to act as its functional nucleus. The first order of business for the Steering Committee was the selection of a director for the Project. By December 1963, a director had been employed and charged with hiring an assistant and a secretary to complete the project staff.[1]

For purposes of this study the state was subdivided into 13 administrative districts.[2] A regional chairman was invited from each district to serve on the Planning Committee. Eventually three more persons were selected on the basis of their special interests to serve as Planning Committee members. With the addition of these, the membership of the Planning Committee totaled 48. Data-gathering committees were formed in all 56 counties of the state. Each of the county committees was composed of a chairman and several members. In most instances, these county committees proved to be active and effectual tools in gathering data concerning their county of residence.

The Planning Committee, as constituted, represented most of the state, county, federal and private agencies interested in promoting better mental health in Montana. The Committee members' day-to-day

---

[1] For names and further data concerning the people who served in some capacity on the Project, see Appendix E.

[2] See Appendix A, Map I showing the 13 administrative districts.

contact with the mental health needs of Montana's citizens was their common bond. The Planning Committee met each quarter of the study period. A primary responsibility was the formation of sub-committees from the Planning Committee membership to survey problem areas of statewide concern.

To achieve this objective the Planning Committee subsequently activated five sub-committees with the following designated areas of responsibility:

1. Legal problems and legislation of state mental hygiene laws: Commitment procedures, licensing, legislation pertaining to mental health services, jurisdictional problems pertaining to non-resident families and Indians, legal definitions of parental rights, adoption, marriage, inter-state and inter-county jurisdiction, federal-state-county responsibility, submission of suggested legislation necessary to effectuate recommendations, etc. Activated January 17, 1964.

2. Manpower and Training:
   Availability and need for manpower to carry out recommended programs, including the kinds, numbers, type of training and methods to obtain these individuals and/or train them. Activated January 17, 1964.

3. Indians:
   Mental health needs of the Indian both on and off the reservation; procedures, rights, privileges, etc. with reference to their status as government wards; coordination of services. Activated April 17, 1964.

4. Alcoholism:
   Facilities, services, problems; the early identification and prevention of alcoholism; the coordination of services; the trends in treatment, etc. Activated April 17, 1964.

5. Public Education and Information Services:
   Newspaper, radio, TV, and other public communication media; general public attitudes toward mental health; trends in public mental health education; provision of accurate information to legislators, county and city officials, PTA's and other groups. Activated April 17, 1964.

The reports from these committees are not separately submitted, but are included within the following text.

## POPULATION UNDER STUDY

The study is based on 1960 Montana population figures as reported by the U.S. Bureau of Census. The report included a total of 674,767 Montana residents, 50.9 percent of whom were males and 49.1 percent females.[1] The population was studied utilizing the following breakdown of age and sex.[2]

TABLE 1.1

GENERAL POPULATION
DETAILED AGE GROUP
BY SEX FOR MONTANA
1960

| AGE INTERVAL | NUMBER IN EACH AGE GROUP | | |
|---|---|---|---|
| | Male | Female | Overall |
| 0 - 4 | 42,184 | 40,918 | 83,102 |
| 5 - 9 | 39,037 | 38,011 | 77,048 |
| 10 - 14 | 33,899 | 33,143 | 67,042 |
| 15 - 19 | 25,429 | 25,338 | 50,767 |
| 20 - 24 | 19,636 | 19,942 | 39,578 |
| 25 - 29 | 19,428 | 19,454 | 38,882 |
| 30 - 34 | 21,241 | 20,488 | 41,729 |
| 35 - 39 | 21,794 | 20,979 | 42,773 |
| 40 - 44 | 21,956 | 21,246 | 43,202 |
| 45 - 49 | 20,670 | 19,269 | 39,939 |
| 50 - 54 | 17,735 | 15,600 | 33,335 |
| 55 - 59 | 15,079 | 13,413 | 28,492 |
| 60 - 64 | 12,009 | 11,449 | 23,458 |
| 65 - 69 | 11,575 | 11,222 | 22,797 |
| 70 - 74 | 10,644 | 9,555 | 20,199 |
| 75 - 79 | 6,821 | 6,122 | 12,943 |
| 80 - 84 | 3,069 | 3,077 | 6,146 |
| 85 + | 1,537 | 1,798 | 3,335 |
| TOTALS | 343,743 | 331,024 | 674,767 |

[1] See Appendix A, Table IV for population of Montana counties.

[2] U.S., Bureau of Census, U.S. Census of Population: 1960, General Population Characteristics, Montana, Final Report PC (1)-28B, p. 28-23.

Estimated population figures were used for the years 1961-63. These estimates were computed by the Division of Records and Statistics of the Montana State Board of Health.[1] Census data for 1950 provided the various demographic and socioeconomic data reported in this study. All adjusted rates as reported throughout the study are based on the utilization of Montana's 1960 population.

## DELINEATION OF DATA

During the process of gathering the data used in the study, it was evident that all individuals who were to be identified as "cases" must fall within a specified definition. For the purpose of this study "case" is defined as an individual who meets the following criteria:

(1) legal resident of the State of Montana;

(2) first seen by a psychiatric resource in any of the following years - 1960, 1961, 1962, 1963;

(3) received into psychiatric treatment for any of the foregoing years.

A concerted effort was expended to make the study as inclusive as possible of every "case", and at the same time forestall the possibility of double counting. Conscientious scrutiny was observed in all presentations to ascertain the verity of the information.

Data were collected for the calendar years 1960 through 1963. However, for some phases studied, specific data were not available for all of the survey years. Periods included will be indicated under the applicable titles throughout the study.

---

[1] See Appendix A, Table III for estimated population figures by age groups.

Data pertaining to first admissions were collected from all sources which could be determined as having relevance to treatment or the establishment of an index of mental illness. Included were the following public sources: Montana State Hospital, mental hygiene clinics, veterans hospitals, Montana State Prison, Boys' Industrial School, and the Girls' Vocational School. Also included were the following private sources: private psychiatrists and private hospitals. For Montana State Hospital and the mental hygiene clinics, data were obtained from IBM data cards; from all other sources, data were obtained through individual surveys of the facilities' records.

Two recent national research studies of significant impact were: Action for Mental Health and More for the Mind. Project members drew from both books; because all citizens should be aware of these studies, a short description is given of each.

Joint Commission on Mental Illness and Health. Action for Mental Health. New York: Basic Books, Inc., 1961.

Action for Mental Health presents the principal findings of the Joint Commission on Mental Illness and Health, empowered by the U.S. Congress to conduct the first study of mental health in America -- and to make recommendations for strengthening it. The report was presented to the U.S. Congress, the Surgeon General and to the governors of the 50 states.

The findings of the five-year study include concrete steps in mental health to be undertaken by federal and state governments and consider both needs and resources realistically. The fully-documented book remains forthright and readable. Research by the Joint Commission

provided material for a series of 10 monographs which formed the basis for Action for Mental Health.

The Joint Commission is a multi-disciplinary organization representing 36 national agencies concerned with mental health and welfare.

Committee on Psychiatric Services. More for the Mind. Toronto: The Canadian Mental Health Association, 1963.

More for the Mind, a similar five-year study by a committee of eight Canadian psychiatrists, dealt specifically with the field of mental illness in Canada. The scope of the Canadian study, as contrasted to the American study, excluded the broad areas of research and public education. Planning was concerned solely with psychiatric illness and treatment. The findings and recommendations are completely annotated by the committee.

Concurrent with the planning for mental health service, there is a study being conducted by a committee on mental retardation. This plan will be made available to the state upon its completion.

## CHAPTER II

## DEMOGRAPHIC ANALYSIS

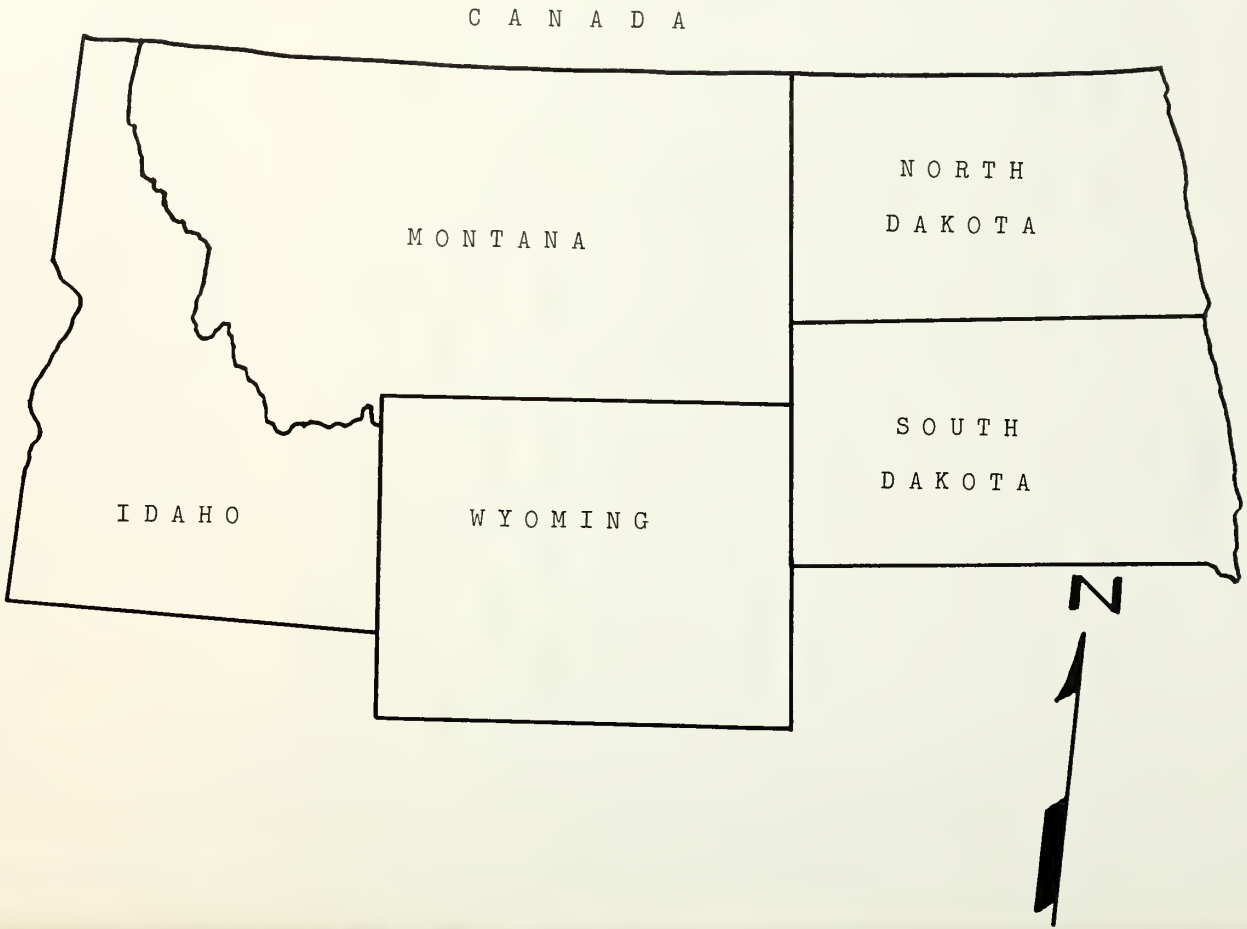
Montana is located in the northwestern region of the United States. It is bordered on the north by Canada, the east by North Dakota and South Dakota, the south by Wyoming, and the south and west by Idaho. The total distance along the boundary is 1,943 miles. (See Map 2.1)

The total area (land and water) is 147,138 square miles; land area, only, is 145,878 square miles. Montana is the fourth largest state in size, but is ranked 42nd in number of population. A concept of the size of Montana can be gained by noting that its land area is greater than that of the New England States, New York, New Jersey, Maryland, and Delaware combined. The length of Montana is about 550 miles (east-west), and the breadth is about 325 miles (north-south). The geographical center is in Fergus County, 12 miles west of Lewistown, the county seat.

Montana's population increased 14.2 percent from 1950 to 1960. Montana's growth kept pace with or exceeded the rates of growth in the neighboring states of Idaho, Wyoming, and North and South Dakota. However, Montana's growth rate did not keep pace with the national increase of 18.5 percent.

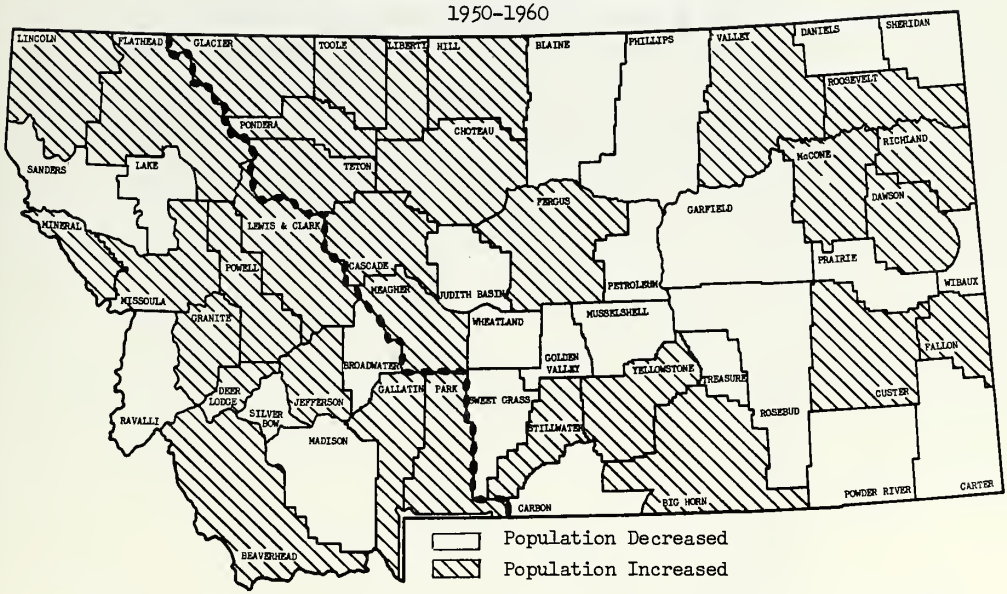
The range of population growth or decrease for Montana counties is from a -18.8 percent in Carbon County to a +50.4 percent in Valley County. Map 2.2 shows that growth rates of 15 of Montana's 56 counties exceeded the state's overall growth rate of 14.2 percent. Twenty-four counties lost population. Of these 24 counties, 22 showed a decrease in population in excess of -3.0 or greater.

MAP 2.1



MAP 2.2

MONTANA POPULATION
RATE OF COUNTY INCREASE OR DECREASE
1950-1960




| | | | | | |
|---|---|---|---|---|---|
| Beaverhead | 7.8 | Granite | 8.7 | Powell | 11.1 |
| Big Horn | 1.9 | Hill | 30.6 | Prairie | -2.5 |
| Blaine | -5.0 | Jefferson | 7.1 | Ravalli | -5.8 |
| Broadwater | -4.0 | Judith Basin | -3.6 | Richland | 1.3 |
| Carbon | -18.8 | Lake | -5.3 | Roosevelt | 22.5 |
| Carter | -10.9 | Lewis & Clark | 14.1 | Rosebud | -5.8 |
| Cascade | 38.5 | Liberty | 20.4 | Sanders | -1.5 |
| Chouteau | 5.4 | Lincoln | 44.2 | Sheridan | -3.2 |
| Custer | 4.5 | McCone | 1.9 | Silver Bow | -4.1 |
| Daniels | -4.8 | Madison | -13.1 | Stillwater | 2.0 |
| Dawson | 35.4 | Meagher | 25.8 | Sweet Grass | -9.1 |
| Deer Lodge | 12.6 | Mineral | 45.9 | Teton | 0.9 |
| Fallon | 9.2 | Missoula | 25.8 | Toole | 15.1 |
| Fergus | 0.0 | Musselshell | -9.6 | Treasure | -4.1 |
| Flathead | 4.7 | Park | 9.7 | Valley | 50.4 |
| Gallatin | 18.9 | Petroleum | -12.9 | Wheatland | -5.1 |
| Garfield | -8.8 | Phillips | -4.9 | Wibaux | -11.0 |
| Glacier | 19.9 | Pondera | 19.7 | Yellowstone | 41.4 |
| Golden Valley | -10.0 | Powder River | -7.7 | | |

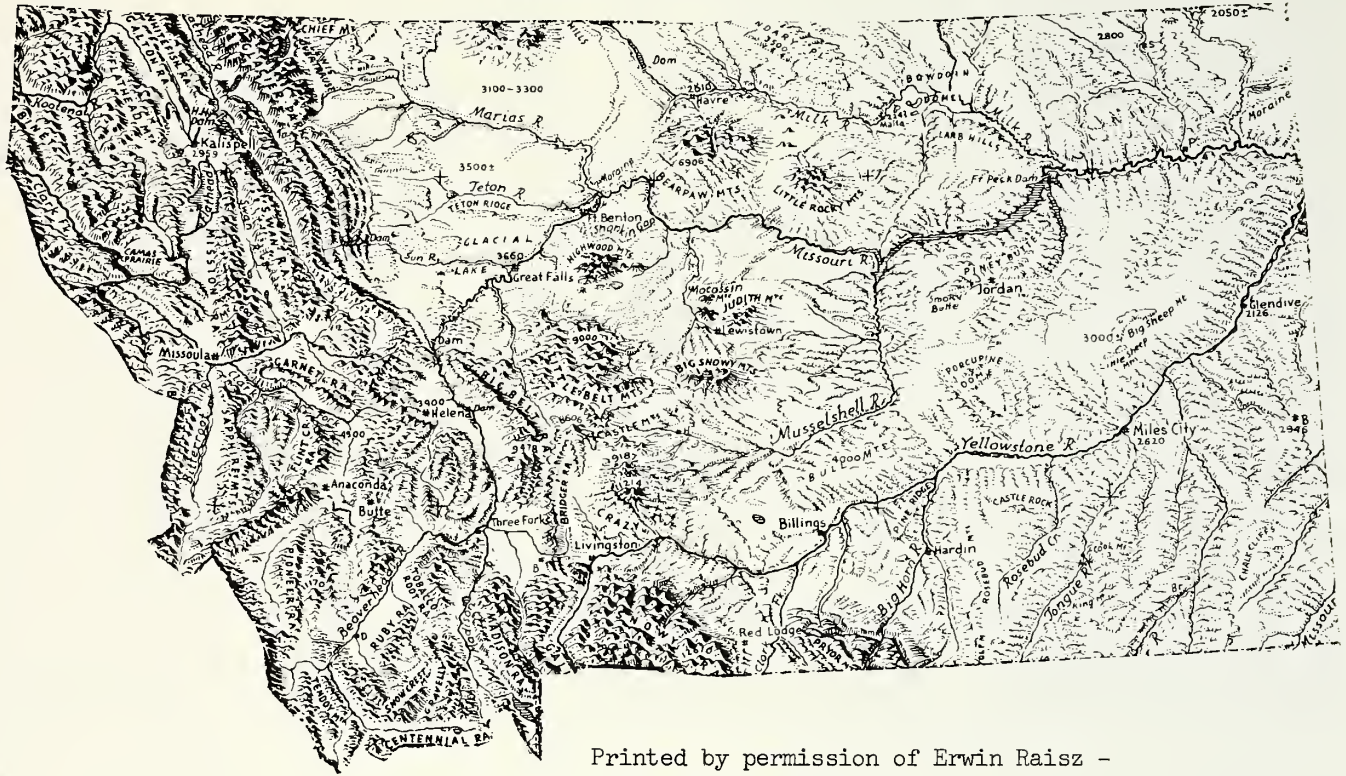
Source: U.S., Bureau of the Census, U.S. Census of Population: 1960, Number of Inhabitants, Montana, Final Report PC (1)-28A, 28-11

The topographical characteristics of Montana are presented in the following statement: (See Map 2.3)

> Montana was aptly named by James M. Ashley, for it contains extensive areas of "mountainous regions".
>
> The Rocky Mountains, wider here than to the south, sprawl across the western portion of the state in long, generally parallel, northwest trending chains, that occupy about one-third (49,000 square miles) of the area of the state. Within this rugged, generally forested region are found 25 or more ranges between which are located many basins and valleys, the larger of which are 10 to 20 miles wide and 25 to 100 miles long. In the southwest, forming the natural boundary between Montana and Idaho are the Centennial and Beaverhead Ranges; in the west, the lofty Bitterroot Range thrusts its saw-toothed peaks and ridges skyward from the Bitterroot Valley. To the north, the mountainous topography is continued by the Cabinet Range and the Purcell Mountains which also lie along the western border of the state. North of the Bitterroot Valley lie the Flathead Valley, Flathead Lake, the Mission Range, with its alp-like peaks, glacial cirques and valleys, and knife-like ridges, and the spectacular glacially-carved mountains and glaciers of Glacier National Park. Stretching eastward and southeastward into the Yellowstone National Park area, and forming the eastern boundary of this region are the Lewis Range, the Big Belt and Little Belt Mountains, the Crazy Mountains and the northern end of the Absaroka Range (Beartooth Uplift).
>
> The Rocky Mountains contain the "backbone of the continent", the Continental Divide. The Divide enters the state from Canada in Glacier National Park, and after pursuing a sinuous course through the western counties, forms the natural line of demarcation between Montana and Idaho for the southern third of that boundary. The Continental Divide has had several important consequences. First, transportation routes have been forced to converge on a few passes, the most important of which are Marias Pass (elev. 5,216') through which the Great Northern Railway and U.S. Highway 2 are routed; Rogers Pass (elev. 5,609'), through which State Highway 20 is routed; McDonald Pass (elev. 6,325'), through which U.S. Highway 10N is routed; Pipestone Pass (elev. 6,418'), through which the Chicago, Milwaukee, St. Paul and Pacific Railway and U.S. Highway 10S are routed; Lost Trail Pass (elev. 7,244'), through which U.S.

MAP 2.3

LANDFORMS OF MONTANA

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Highway 93 is routed; Monida Pass (elev. 6,823'), through which the Union Pacific Railway (Oregon Short Line) and U.S. Highway 91 are routed; and Targhee Pass (elev. 7,078'), through which U.S. Highway 191, furnishing access to the West Entrance of Yellowstone National Park, is routed. Second, the Divide controls the drainage pattern; to the west the waters flow to the Pacific Ocean via the Columbia River, and to the east to the Gulf of Mexico via the Missouri-Mississippi River. Third, the Divide and associated mountains exert an influence on Montana's climate; to the west is felt the semi-maritime influence of the Pacific Ocean, while to the east the continental influence is dominant.

Stretching across the eastern two-thirds of the state are the Great Plains. Commencing as broad piedmont slopes more than 3,500' above sea-level, the plains slope gently from the foothills of the Rockies toward the north-eastern portion of the state, where elevations as low as 1,900' are found along the course of the Missouri River. The stark vastness of the plains is broken by prominent, isolated mountainous areas such as the Bear Paw, Little Rocky, Highwood, Moccasin, Judith, Big Snowy and Big Horn Mountains. The levelness of the plains is further modified by the streams that have entrenched themselves in a dendritic pattern of broad fertile valleys paralleled by back-stepped benches and bluffs.

The mean elevation of Montana is approximately 3,400', the lowest for the Rocky Mountain states, although considerable areas, especially in the western region, have elevations in excess of 5,000'. The highest elevation, 12,850' is the summit of Granite Peak, in Park County, near the south-central boundary. There are four peaks in excess of 12,000', 13 in excess of 11,000', and 48 in excess of 10,000'. The lowest elevation, 1,800', occurs in Lincoln County in the northwest where the Kootenai River leaves the state.[1]

Because of the distinct topographical variation of Montana from mountains in the west to plains in the eastern portion, it is apropos to this analysis that Montana's counties be differentiated as to being either a mountain or a plains area. The broken line on Map 2.2 separates the 38 plains counties from the 18 mountain counties.

[1] The Montana Almanac, 1959-60 (Missoula, Montana: Montana State University Press, 1958), pp. 3-7.

Of the 38 plains counties, 18 show a decrease in their population. These 18 counties, without exception, have continued to lose population since 1940 and most have shown a decreasing situation since 1920, some losing as much as 50 percent of their population during this period of time. The 20 remaining plains counties all have urban centers that have increased in population, thus either maintaining the total county populace at previous levels or causing the county to show an increase.

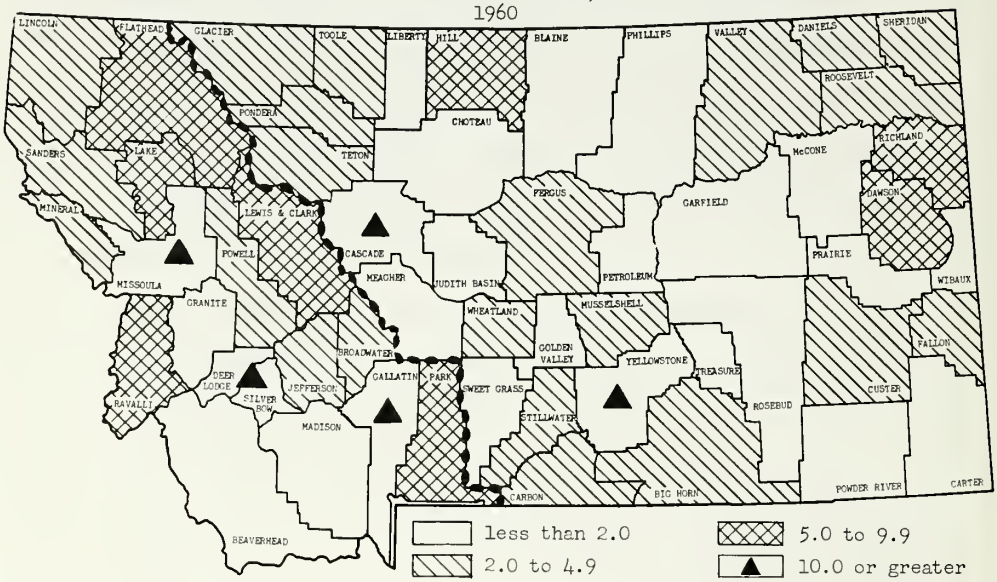
Of the 18 mountain counties, six showed a decrease in population. With the one exception of Silver Bow County, these six are classed in 1960 as 100 percent rural counties -- their populace being either rural farm or rural nonfarm.[1] The remaining 12 mountain counties all show an increase in population, with much the same pattern of urbanization found in the plains counties serving as the catalyst to growth. Overall, about 44 percent of the plains counties increased in population: progressive urban centers were unquestionably the determining factor in growth of county population.

Map 2.4 shows the density of population by county with the broken line separating the mountain counties from the plains counties. Six counties have a population density of more than 10 persons per square mile and include approximately one-half of Montana's population. (Of these six counties, two - Cascade and Yellowstone - are located in the plains area.) Only Alaska, Wyoming and Nevada have lower population density than Montana. The extremely low density of population in 49 of Montana's counties presents many unusual problems for government organization

[1]U.S., Bureau of the Census, U.S. Census of Population: 1960, General Social and Economic Characteristics, Montana, Final Report PC (1)-28C, pp. 28-84, 85.

MAP 2.4

NUMBER OF PERSONS PER SQUARE MILE, MONTANA COUNTIES
1960



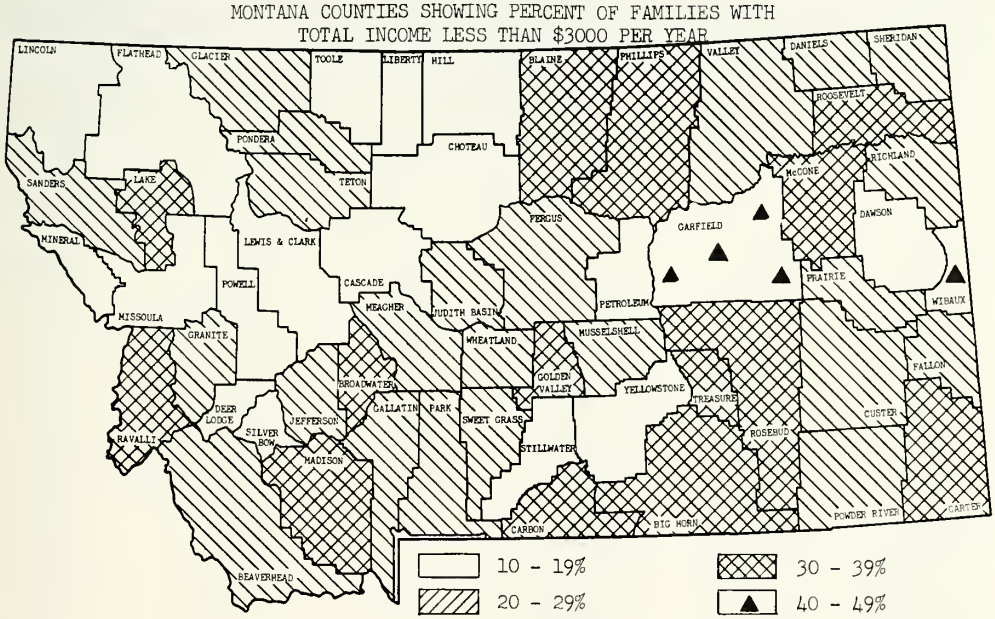

| | | | | | |
|---|---|---|---|---|---|
| Beaverhead | 1.3 | Granite | 1.7 | Powell | 3.0 |
| Big Horn | 2.0 | Hill | 6.4 | Prairie | 1.3 |
| Blaine | 1.9 | Jefferson | 2.6 | Ravalli | 5.2 |
| Broadwater | 2.3 | Judith Basin | 1.6 | Richland | 5.1 |
| Carbon | 4.0 | Lake | 8.7 | Roosevelt | 4.9 |
| Carter | 0.8 | Lewis & Clark | 8.1 | Rosebud | 1.2 |
| Cascade | 27.6 | Liberty | 1.8 | Sanders | 2.5 |
| Chouteau | 1.9 | Lincoln | 3.4 | Sheridan | 3.8 |
| Custer | 3.5 | McCone | 1.3 | Silver Bow | 64.9 |
| Daniels | 2.6 | Madison | 1.5 | Stillwater | 3.1 |
| Dawson | 5.2 | Meagher | 1.1 | Sweet Grass | 1.8 |
| Deer Lodge | 25.3 | Mineral | 2.5 | Teton | 3.2 |
| Fallon | 2.4 | Missoula | 17.1 | Toole | 4.1 |
| Fergus | 3.3 | Musselshell | 2.6 | Treasure | 1.4 |
| Flathead | 6.4 | Park | 5.0 | Valley | 3.4 |
| Gallatin | 10.3 | Petroleum | 0.5 | Wheatland | 2.1 |
| Garfield | 0.4 | Phillips | 1.2 | Wibaux | 1.9 |
| Glacier | 3.9 | Pondera | 4.7 | Yellowstone | 30.0 |
| Golden Valley | 1.0 | Powder River | 0.8 | | |

and finance. The geographic median incomes of families and percentage of families living on a total income of less than $3,000 per year would indicate that many counties have a restricted tax base, and that financing local governments would present problems in these areas. (See Maps 2.5 and 2.6)

The counties with highest population density have well defined urban centers.[1] Of the nine urban centers, Anaconda and Butte failed to grow at a rate faster than the state average.

MAP 2.5

MONTANA COUNTIES SHOWING PERCENT OF FAMILIES WITH TOTAL INCOME LESS THAN $3000 PER YEAR

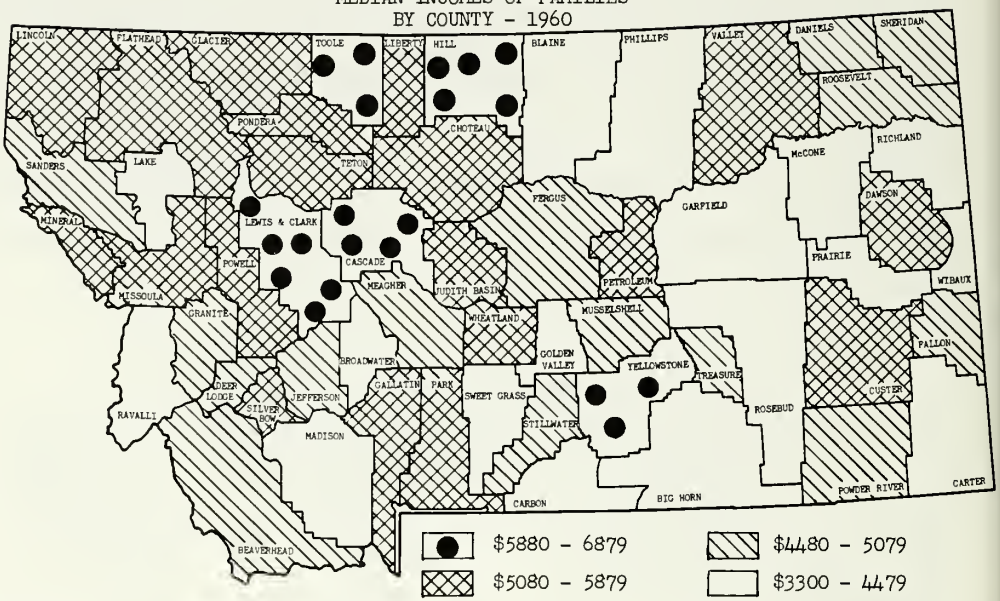



The 1960 census reports 67 urban areas in Montana with 1,000 population or more. Table 2.1 reports these urban areas with their percent

[1] Urban center is defined as all incorporated and unincorporated places with 10,000 population or more.

MAP 2.6

MONTANA
MEDIAN INCOMES OF FAMILIES
BY COUNTY - 1960




| | | | | | |
|---|---|---|---|---|---|
| Beaverhead | $4998 | Granite | $4937 | Powell | $5384 |
| Big Horn | 4375 | Hill | 6210 | Prairie | 4470 |
| Blaine | 4416 | Jefferson | 4989 | Ravalli | 3819 |
| Broadwater | 3988 | Judith Basin | 5332 | Richland | 4462 |
| Carbon | 4336 | Lake | 4183 | Roosevelt | 4562 |
| Carter | 4199 | Lewis & Clark | 6461 | Rosebud | 4399 |
| Cascade | 6032 | Liberty | 5858 | Sanders | 4969 |
| Chouteau | 5610 | Lincoln | 5483 | Sheridan | 4550 |
| Custer | 5160 | McCone | 3915 | Silver Bow | 5283 |
| Daniels | 4488 | Madison | 4470 | Stillwater | 4790 |
| Dawson | 5554 | Meagher | 4949 | Sweet Grass | 4333 |
| Deer Lodge | 5022 | Mineral | 5788 | Teton | 5267 |
| Fallon | 4694 | Missoula | 5769 | Toole | 6023 |
| Fergus | 4992 | Musselshell | 4927 | Treasure | 4538 |
| Flathead | 5392 | Park | 5253 | Valley | 5325 |
| Gallatin | 5360 | Petroleum | 5418 | Wheatland | 5400 |
| Garfield | 3311 | Phillips | 4353 | Wibaux | 3431 |
| Glacier | 5169 | Pondera | 5078 | Yellowstone | 6150 |
| Golden Valley | 4044 | Powder River | 4797 | | |

of increase or decrease from the 1950 census figures. Superior had the highest percent (98.4) population increase. Of the incorporated cities, Red Lodge had the greatest decrease in its population, showing a decline of 16.6 percent, with Butte a close second - having a decline of 16.2 percent. Forty of the urban areas showed an increase in population in excess of the state growth rate of 14.2 percent. Nine of the 67 cities showed a decrease in their population ranging from -1.1 to -16.6 percent.

The decline noted in Butte must be scrutinized more closely in order to ascertain the factual situation. Since 1950, two suburban districts have developed in the outlying sectors of the city. In 1960, the population of these two districts combined was 8,877 people; therefore, although the city of Butte declined by 5,374 persons, the indication is that this decline merely represents a move to suburbia. Considering these statistics we find that Butte and adjacent areas actually increased by 3,503 persons or 10.5 percent over 1950.

It is evident that a close correlation exists between the urban areas in Table 2.1 that show a marked increase in their population and those counties on Map 2.2 that show a similar increase in population. This, in conjunction with the easily discernible fact that most of Montana's predominantly rural counties either lost populace from 1950 to 1960 or show a very insignificant increase (see Maps 2.7 and 2.8), would indicate that Montana's population movement trend is to become increasingly urban ized.

TABLE 2.1

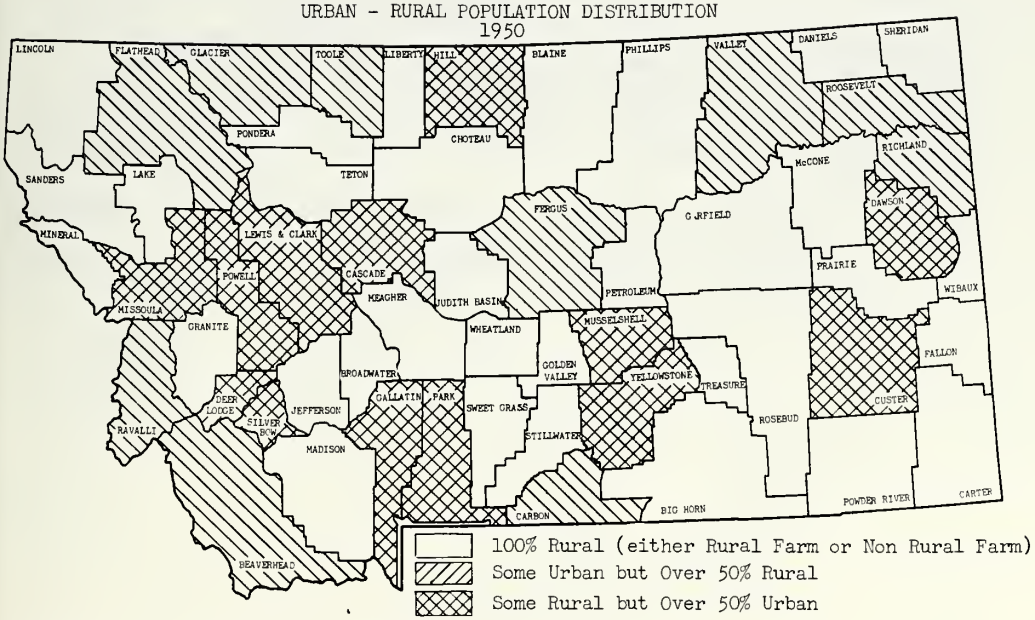
POPULATION OF INCORPORATED
AND UNINCORPORATED PLACES IN MONTANA
OF 1,000 OR MORE
SHOWING PERCENT OF INCREASE OR DECREASE
FROM 1950 TO 1960

| PLACES | 1960 | 1950 | % INC. OR DEC. | PLACES | 1960 | 1950 | % INC. OR DEC. |
|---|---|---|---|---|---|---|---|
| Anaconda | 12,054 | 11,254 | 7.1 | Havre | 10,740 | 8,086 | 32.8 |
| Baker | 2,365 | 1,772 | 33.5 | Helena | 20,227 | 17,581 | 15.1 |
| Belgrade | 1,057 | 663 | 59.4 | Kalispell | 10,151 | 9,737 | 4.3 |
| Big Timber | 1,660 | 1,679 | -1.1 | Laurel | 4,601 | 3,663 | 25.6 |
| Billings | 52,851 | 31,834 | 66.0 | Lewistown | 7,408 | 6,573 | 12.7 |
| Boulder | 1,394 | 1,017 | 37.1 | Libby | 2,828 | 2,401 | 17.8 |
| Bozeman | 13,361 | 11,325 | 18.0 | Livingston | 8,229 | 7,683 | 7.1 |
| Browning | 2,011 | 1,691 | 18.9 | Malta | 2,239 | 2,095 | 6.9 |
| Butte | 27,877 | 33,251 | -16.2 | Meaderville- | | | |
| Centerville - | | | | McQueen (u) | 1,345 | 1,704 | -21.1 |
| Dublin Gulch (u) | 3,398 | 1,825 | 86.2 | Miles City | 9,665 | 9,243 | 4.6 |
| Chester | 1,158 | 733 | 58.0 | Missoula | 27,090 | 22,485 | 20.5 |
| Chinook | 2,326 | 2,307 | .8 | North Havre (u) | 1,168 | - | - |
| Choteau | 1,966 | 1,618 | 21.5 | Orchard Homes (u) | 2,019 | 1,545 | 30.7 |
| Circle | 1,117 | 856 | 30.5 | Philipsburg | 1,107 | 1,048 | 5.6 |
| Columbia Falls | 2,132 | 1,232 | 73.1 | Plentywood | 2,121 | 1,862 | 13.9 |
| Columbus | 1,281 | 1,097 | 16.8 | Polson | 2,314 | 2,280 | 1.5 |
| Conrad | 2,665 | 1,865 | 42.9 | Poplar | 1,565 | 1,169 | 33.9 |
| Cut Bank | 4,539 | 3,721 | 22.0 | Red Lodge | 2,278 | 2,730 | -16.6 |
| Deer Lodge | 4,681 | 3,779 | 23.9 | Ronan | 1,334 | 1,251 | 6.6 |
| Dillon | 3,690 | 3,268 | 12.9 | Roundup | 2,842 | 2,856 | -.5 |
| East Helena | 1,490 | 1,216 | 22.5 | Scobey | 1,726 | 1,628 | 6.0 |
| Eureka | 1,229 | 929 | 32.3 | Shelby | 4,017 | 3,058 | 31.4 |
| Fairview | 1,006 | 942 | 6.8 | Sidney | 4,564 | 3,987 | 14.5 |
| Floral Park (u) | 4,079 | - | - | Silver Bow Park (u) | 4,798 | - | - |
| Forsyth | 2,032 | 1,906 | 6.6 | Superior | 1,242 | 626 | 98.4 |
| Fort Benton | 1,887 | 1,522 | 24.0 | Terry | 1,140 | 1,191 | -4.3 |
| Glasgow | 6,398 | 3,821 | 67.4 | Thompson Falls | 1,274 | 851 | 49.7 |
| Glendive | 7,058 | 5,254 | 34.3 | Three Forks | 1,161 | 1,114 | 4.2 |
| Great Falls | 55,357 | 39,214 | 41.2 | Townsend | 1,528 | 1,316 | 16.1 |
| Hamilton | 2,475 | 2,678 | -7.6 | Walkerville | 1,453 | 1,631 | -10.9 |
| Hardin | 2,789 | 2,306 | 20.9 | Whitefish | 2,965 | 3,268 | -9.3 |
| Harlem | 1,267 | 1,107 | 22.6 | White Sulphur Springs | 1,519 | 1,025 | 48.2 |
| Harlowton | 1,734 | 1,733 | .1 | Wolf Point | 3,585 | 2,557 | 40.2 |

Source: U.S., Bureau of the Census, U.S. Census of Population: 1960, Number of Inhabitants. Montana, Final Report PC (1)-28A, p. 28-14

MAP 2.7

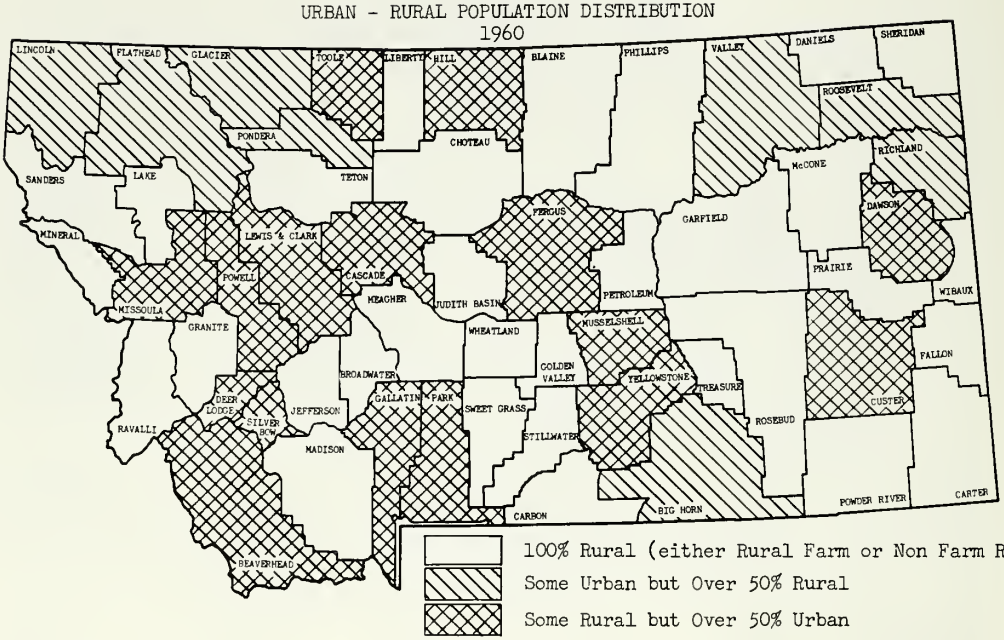
MONTANA
URBAN - RURAL POPULATION DISTRIBUTION
1950




| | | | | | |
|---|---|---|---|---|---|
| Beaverhead | 49.0 | Granite | 100.0 | Powell | 60.0 |
| Big Horn | 100.0 | Hill | 56.6 | Prairie | 100.0 |
| Blaine | 100.0 | Jefferson | 100.0 | Ravalli | 20.4 |
| Broadwater | 100.0 | Judith Basin | 100.0 | Richland | 38.5 |
| Carbon | 26.7 | Lake | 100.0 | Roosevelt | 26.7 |
| Carter | 100.0 | Lewis & Clark | 71.6 | Rosebud | 100.0 |
| Cascade | 74.0 | Liberty | 100.0 | Sanders | 100.0 |
| Chouteau | 100.0 | Lincoln | 100.0 | Sheridan | 100.0 |
| Custer | 73.0 | McCone | 100.0 | Silver Bow | 79.3 |
| Daniels | 100.0 | Madison | 100.0 | Stillwater | 100.0 |
| Dawson | 57.8 | Meagher | 100.0 | Sweet Grass | 100.0 |
| Deer Lodge | 68.0 | Mineral | 100.0 | Teton | 100.0 |
| Fallon | 100.0 | Missoula | 63.4 | Toole | 44.5 |
| Fergus | 46.9 | Musselshell | 52.8 | Treasure | 100.0 |
| Flathead | 41.3 | Park | 64.0 | Valley | 33.7 |
| Gallatin | 51.7 | Petroleum | 100.0 | Wheatland | 100.0 |
| Garfield | 100.0 | Phillips | 100.0 | Wibaux | 100.0 |
| Glacier | 38.6 | Pondera | 100.0 | Yellowstone | 63.5 |
| Golden Valley | 100.0 | Powder River | 100.0 | | |

MAP 2.8

MONTANA
URBAN - RURAL POPULATION DISTRIBUTION
1960




| | | | | | |
|---|---|---|---|---|---|
| Beaverhead | 51.3 | Granite | 100.0 | Powell | 66.8 |
| Big Horn | 27.9 | Hill | 57.6 | Prairie | 100.0 |
| Blaine | 100.0 | Jefferson | 100.0 | Ravalli | 100.0 |
| Broadwater | 100.0 | Judith Basin | 100.0 | Richland | 43.5 |
| Carbon | 100.0 | Lake | 100.0 | Roosevelt | 30.6 |
| Carter | 100.0 | Lewis & Clark | 72.3 | Rosebud | 100.0 |
| Cascade | 78.5 | Liberty | 100.0 | Sanders | 100.0 |
| Chouteau | 100.0 | Lincoln | 22.6 | Sheridan | 100.0 |
| Custer | 73.1 | McCone | 100.0 | Silver Bow | 86.4 |
| Daniels | 100.0 | Madison | 100.0 | Stillwater | 100.0 |
| Dawson | 57.3 | Meagher | 100.0 | Sweet Grass | 100.0 |
| Deer Lodge | 64.6 | Mineral | 100.0 | Teton | 100.0 |
| Fallon | 100.0 | Missoula | 69.2 | Toole | 50.8 |
| Fergus | 52.9 | Musselshell | 58.1 | Treasure | 100.0 |
| Flathead | 39.8 | Park | 71.2 | Valley | 37.5 |
| Gallatin | 51.3 | Petroleum | 100.0 | Wheatland | 100.0 |
| Garfield | 100.0 | Phillips | 100.0 | Wibaux | 100.0 |
| Glacier | 39.2 | Pondera | 34.9 | Yellowstone | 82.7 |
| Golden Valley | 100.0 | Powder River | 100.0 | | |

From 1950 to 1960,[1] most of the counties show a general increase in urbanization. The county showing the greatest increase in urbanization was Pondera, which moved from a 100 percent rural classification to 34.9 percent urban. This increase, however, is somewhat misleading in that Conrad (Pondera County's largest urban center) was just under the population requirement to be classed as urban in 1950 and a little over the requirement in 1960. Essentially then, the Pondera County urban center was already existent in 1950, and the actual increase to 1960 was only 12.5 percent. Big Horn and Lincoln Counties exhibit nearly identical situations, with Hardin and Libby as the urban centers; in both, actual growth indicates a 4.9 percent increase. In two counties, Carbon and Ravalli, the reverse of the above process occurred; they moved from urbanization of 26.7 percent and 20.4 percent respectively to a 100 percent rural classification; their actual decreases being respectively 5.4 percent and 1.6 percent. With few exceptions, the remainder of the counties show a decided increase in the percent of rural nonfarm inhabitants, further indicating that Montana's population is becoming more urbanized.

Between 1950 and 1960, Montana's population increased 83,743 or about 14.2 percent.[2] The natural increase during the same time for the state was about 18.3 percent or 108,373. Net migration was approximately 4.2 percent or 24,630. It is suggested that between 2500 and 3000 Montanans leave the state each year primarily for employment or retirement reasons.

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[1] U.S., Bureau of the Census, U.S. Census of Population: 1960, Number of Inhabitants, Montana, Final Report PC (1)-28A, pp. 28-11.

[2] Based on 1950 Census of Population.

A population pyramid showing age and sex with comparisons from 1950 to 1960 is reported on Table 2.2. There is a noticeable increase in the young age group (0-18) from the 1950 census figures, and a similar increase is reflected in the age grouping 65 and older. There is a decrease in age group 20 - 34 from the 1950 figures. Each year a significant number of young people in the important productive-years age bracket leave Montana. The remaining population tends to increase the proportion of older people in the state.

The state's youth, 0 - 18 age group, increased 33.6 percent, and the older population, age 65 and over, increased 28.6 percent. The population increase in the productive years, age 18 - 64, however was only 1.1 percent. The bearing of this latter factor upon the tax base of the state and its ability to finance necessary services and facilities is quite apparent. In addition, the large aged population has its own unique health needs. Table 2.3 shows the percent of the population falling into the previously listed age categories by urban and rural residence, and provides a comparison with the 1950 census breakdown.

The 13 administrative districts were broken down by the percent of distribution of population under 18 years, 18 - 64, and 65 and over. These facts are compared with the 1950 census figures and presented on Table 2.4.

TABLE 2.2

MONTANA POPULATION PYRAMID
COMPARING CENSUS YEARS
1950 AND 1960

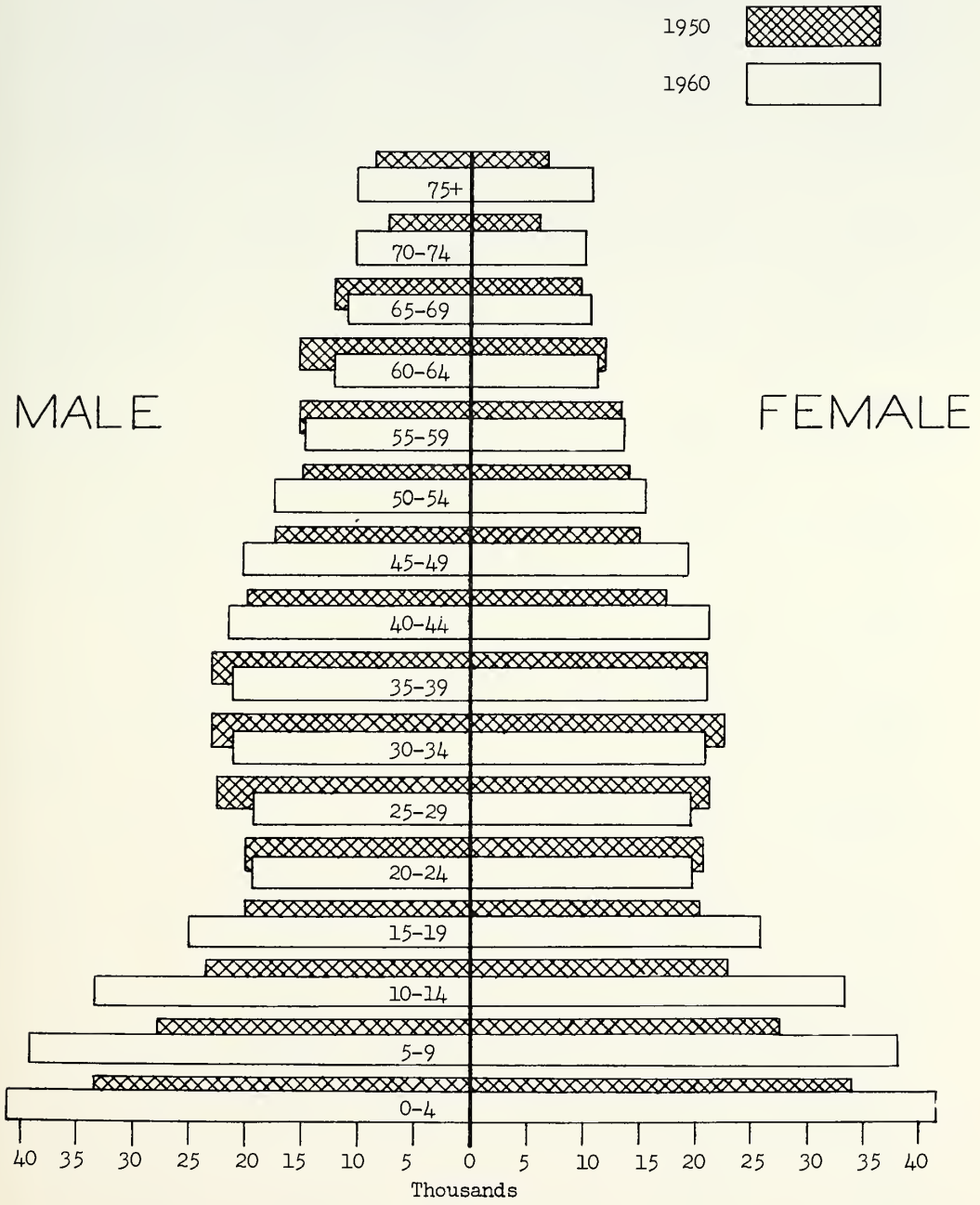

TABLE 2.3

DEPENDENCY RATIO OF THE CENSUS YEARS
1950 AND 1960

| RESIDENT AREA | DEPENDENCY RATIO /1000 | YEAR | PERCENTAGE DISTRIBUTION OF MONTANA'S POPULATION BY AGE GROUPINGS | | |
|---|---|---|---|---|---|
| | | | Under 18 | 18 - 64 | 65 and over |
| MONTANA | 712 | 1950 | 33.0% | 58.4% | 8.6% |
| | 934 | 1960 | 38.6% | 51.7% | 9.7% |
| URBAN | 623 | 1950 | 29.2% | 61.6% | 9.2% |
| | 883 | 1960 | 36.9% | 53.1% | 10% |
| RURAL | 783 | 1950 | 35.8% | 56.1% | 8.1% |
| | 988 | 1960 | 40.3% | 50.3% | 9.4% |

The dependency ratio[1] for Montana in 1950 was 712 per 1,000 and in 1960 it was 934 per 1,000 in the productive age group. The urban population had a dependency ratio of 623 for 1950 and 883 in 1960 per 1,000 in the productive age group. The rural population dependency ratio for 1950 was 782 and in 1960, 988 per 1,000 in the productive age group. These high rates do not reflect the total picture. A sizeable proportion

[1] The dependency ratio is computed by use of the following formula: Percent in productive category / percent in non-productive category = 1000 / x = DR; and is further defined as the proportion of the total population under 18 years of age and 65 or older.

TABLE 2.4

DEPENDENCY RATIO OF THE CENSUS YEARS 1950 AND 1960
FOR THE 13 ADMINISTRATIVE DISTRICTS

| DIS-TRICT | DEPENDENCY PER 1,000 | YEAR | PERCENTAGE DISTRIBUTION OF MONTANA POPULATION BY AGE GROUPINGS | | |
|---|---|---|---|---|---|
| | | | Under 18 | 18 - 64 | 65 and over |
| 1 | 783 | 1950 | 34.9% | 56.1% | 9.0% |
| | 1004 | 1960 | 39.3% | 49.8% | 10.9% |
| 2 | 774 | 1950 | 37.4% | 56.2% | 6.4% |
| | 1004 | 1960 | 42.9% | 49.9% | 7.2% |
| 3 | 788 | 1950 | 36.4% | 55.9% | 7.7% |
| | 1020 | 1960 | 41.8% | 49.5% | 8.7% |
| 4 | 818 | 1950 | 37.1% | 55.0% | 7.9% |
| | 1028 | 1960 | 41.3% | 49.3% | 9.4% |
| 5 | 811 | 1950 | 36.8% | 55.2% | 8.0% |
| | 1061 | 1960 | 42.2% | 48.5% | 9.3% |
| 6 | 757 | 1950 | 32.7% | 56.9% | 10.4% |
| | 1036 | 1960 | 37.9% | 49.1% | 13.0% |
| 7 | 661 | 1950 | 31.8% | 60.2% | 8.0% |
| | 890 | 1960 | 38.9% | 52.9% | 8.2% |
| 8 | 669 | 1950 | 30.8% | 59.9% | 9.3% |
| | 886 | 1960 | 36.6% | 53% | 10.4% |
| 9 | 626 | 1950 | 28.9% | 61.5% | 9.6% |
| | 862 | 1960 | 35.7% | 53.7% | 10.6% |
| 10 | 689 | 1950 | 31.4% | 59.2% | 9.4% |
| | 883 | 1960 | 36.4% | 53.1% | 10.5% |
| 11 | 644 | 1950 | 30.1% | 60.8% | 9.1% |
| | 841 | 1960 | 35.1% | 54.3% | 10.6% |
| 12 | 727 | 1950 | 34.2% | 57.9% | 7.9% |
| | 923 | 1960 | 39.5% | 52% | 8.5% |
| 13 | 751 | 1950 | 34.3% | 57.1% | 8.6% |
| | 1008 | 1960 | 39.4% | 49.8% | 10.8% |

of women in the productive age (18-64) do not contribute economically. It is probably safe to assume that approximately half of the productive force are women, and if this group would be added to the non-productive group, the dependency ratios would be considerably higher.

CHAPTER III

## MENTAL DISORDERS BY AGE AND SEX

Age and sex are fundamental demographic material in the understanding of prevalence rates of disease. Age is an index of the individual's life experience and exposure to disease. The sex of the individual indicates differing psychological and sociological environments. An understanding of age and sex rates and the distribution of these rates will contribute measurably to planning for the comprehensive mental health needs of Montana's population.

### MONTANA STATE HOSPITAL

Montana State Hospital was surveyed for calendar years 1960 through 1963. The total first admissions for this four-year study period were 3,307. Of this number, 2,203 or 66.62 percent were male and 1,104 or 33.38 percent were female. The average number of first admissions per year for this four-year period was 550.5 male, 276.3 female and 826.8 total. This data is presented in Table 3.1. These averages include all reported first admissions into Montana State Hospital. Therefore, the figures include non-residents of Montana as well as persons for whom a place of legal residence could not be determined and who thus were classified as "residence unknown".

For purposes of this study, total first admissions of 3,307 were adjusted to meet the study definition of a Montana "case".[1] Table 3.1 also presents these adjusted findings.

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[1] Any legal resident of the state of Montana who was diagnosed as having a psychiatric problem and was seen for the first time in any of the following years: 1960, 1961, 1962, 1963, for psychiatric treatment.

TABLE 3.1

SUMMARY OF FIRST ADMISSIONS
TO MONTANA STATE HOSPITAL
SHOWING RESIDENT ADMISSIONS, NON-RESIDENT ADMISSIONS
AND RESIDENT ALCOHOLIC ADMISSIONS BY YEAR AND SEX
1960-1963

| YEAR | MALE | | | | FEMALE | | | | COMBINED | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | TOTAL 1ST ADMISSION | RESIDENT ADM. | NON-RES. ADMISSION | RES. ALCOHOLICS | TOTAL 1ST ADMISSION | RESIDENT ADM. | NON-RES ADMISSION | RES. ALCOHOLICS | TOTAL 1ST ADMISSION | RESIDENT ADM. | NON-RES. ADMISSION |
| 1960 | 586 | 581 | 5 / .9% | 242 | 297 | 297 | 0 | 42 | 883 | 878 | 5 / .6% |
| 1961 | 559 | 551 | 8 / 1.4% | 154 | 256 | 255 | 1 / .4% | 29 | 815 | 806 | 9 / 1.1% |
| 1962 | 497 | 464 | 33 / 6.6% | 199 | 277 | 260 | 17 / 6.1% | 35 | 774 | 724 | 50 / 6.5% |
| 1963 | 561 | 505 | 56 / 10% | 174 | 274 | 260 | 14 / 5.1% | 19 | 835 | 765 | 70 / 8.4% |
| FOUR YEAR TOTALS | 2203 | 2101 | 102 / 4.6% | 769 | 1104 | 1072 | 32 / 2.9% | 125 | 3307 | 3173 | 134 / 4% |

A significant increase appears in the number of non-residents seeking admission or committed for the first time to the State Hospital from the biennium 1960-1961 to the 1962-1963 biennium. This was greatly due to a change in data processing which increased the accuracy of the statistics recorded during the admission procedure.

During the four-year period studied, 134 first admissions were deleted from further statistical analysis -- 90 percent of these were found in the years 1962 and 1963. The majority of cases deleted were non-residents; however, for 41 of the 134, a place of residence could not be determined.

An average annual first admission rate into Montana State Hospital, based on an average of the four years (1960-1963), is reported on Table 3.2. The median age for males was 42.26; females - 43.32. The admission rates for males were higher than those of females. This finding is in keeping with other studies of first admissions to state hospitals.

The sharp increase from the under 15 years to the next age group in the age specific rate for males is significant. A more gradual increase prevails through age group 35-44; then a near reverse pattern occurs through the advancing age groupings. However, the age group of 75 and over shows a significant increase, primarily, as will be explained in succeeding chapters, because of the large aged population in the state.

The rate for females indicates a similar sharp increase to the second age grouping. The next age groupings through 74 remain fairly static as to age specific rate. Again there is a substantial increase in the age group of 75 and over.

TABLE 3.2

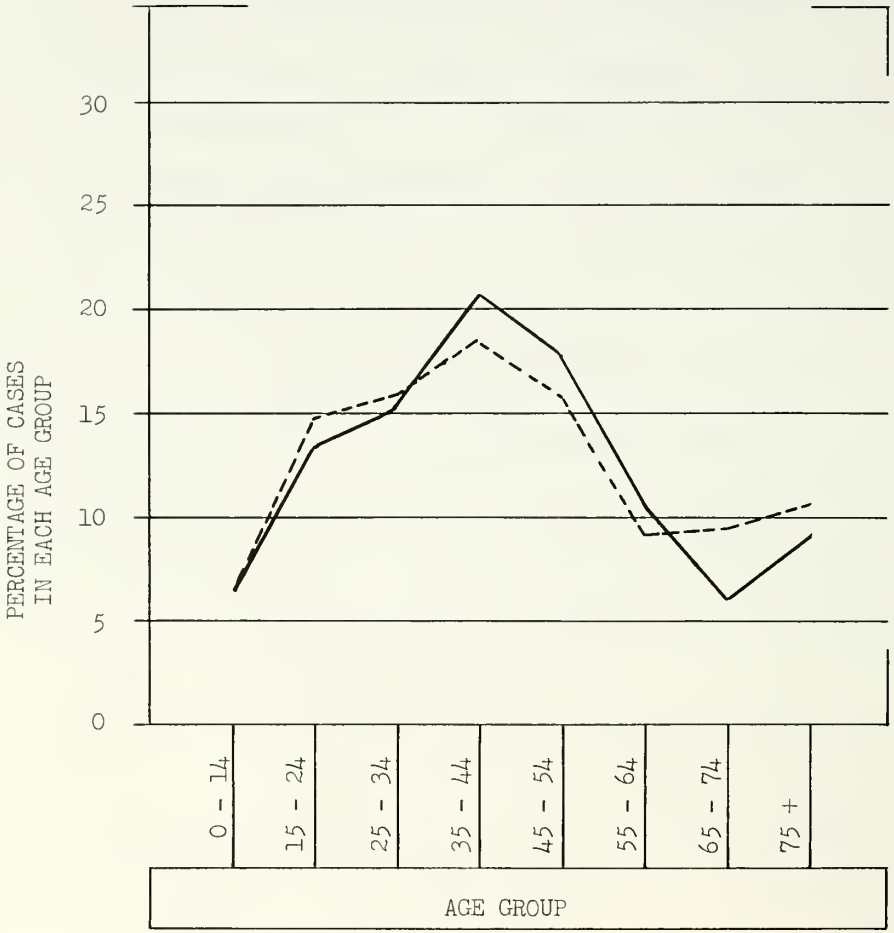
MONTANA STATE HOSPITAL
FIRST ADMISSION AVERAGES 1960-1963
AGE-SEX SPECIFIC RATES PER 1,000 MONTANA POPULATION

| AGE GROUP | MALE | | FEMALE | | TOTAL | | TOTAL PERCENTAGE FOUND IN EACH AGE GROUP |
|---|---|---|---|---|---|---|---|
| | AVERAGE NUMBER OF CASES | AGE SPECIFIC RATE | AVERAGE NUMBER OF CASES | AGE SPECIFIC RATE | AVERAGE NUMBER OF CASES | AGE SPECIFIC RATE | |
| Under 15 | 33.50 | .3 | 17.25 | .1 | 50.75 | .2 | 6.4 |
| 15 to 24 | 69.00 | 1.5 | 38.50 | .8 | 107.50 | 1.1 | 13.6 |
| 25 to 34 | 80.25 | 1.9 | 42.25 | 1.0 | 122.50 | 1.4 | 15.4 |
| 35 to 44 | 110.00 | 2.4 | 49.25 | 1.1 | 159.25 | 1.8 | 20.1 |
| 45 to 54 | 92.25 | 2.3 | 42.50 | 1.2 | 134.75 | 1.8 | 17.0 |
| 55 to 64 | 57.50 | 2.0 | 23.75 | .9 | 81.25 | 1.5 | 10.2 |
| 65 to 74 | 33.75 | 1.5 | 25.50 | 1.2 | 59.25 | 1.3 | 7.5 |
| 75 and over | 49.00 | 4.1 | 29.00 | 2.5 | 78.00 | 3.3 | 9.8 |
| Totals | 525.25 | | 268.00 | | 793.25 | | |
| Adjusted Rate | | 1.5 | | .8 | | 1.1 | |
| Median Age | 42.26 | | 43.32 | | 42.54 | | |

Chart 3.1 shows the distribution of first admission averages for years 1960-1963 to Montana State Hospital by percent in each age group by sex.

CHART 3.1

MONTANA STATE HOSPITAL FIRST ADMISSIONS
PERCENTAGE OF PATIENTS FOUND IN EACH AGE GROUP *




* Based on average admissions for 1960-1963

Male
Female

## ALCOHOLIC ADMISSIONS

The alcoholic admissions represent a sizeable number of first admissions each year to Montana State Hospital. For this reason, alcoholic admissions will be treated separately.

During the four-year period of this study (1960-1963) alcoholic first admissions averaged 223.5 or 28.16 percent of the total first admissions. The average first admission percentage for males was 36.6 and 11.7 for females. The average age sex specific rate for the four-year average period is reported on Table 3.3.

The highest age-sex specific rate is found in age groups 35 - 44. This was true for both males and females; however, it is significant to note that nearly 82 percent of all alcoholics were found in the most productive years between the ages of 25 and 54.

TABLE 3.3

ALCOHOLIC FIRST ADMISSIONS TO MONTANA STATE HOSPITAL
FOUR YEAR AVERAGES 1960-1963
AGE-SEX SPECIFIC RATES PER 1,000 MONTANA POPULATION

| AGE GROUP | MALE | | FEMALE | | TOTAL | | TOTAL PERCENTAGE FOUND IN EACH AGE GROUP |
|---|---|---|---|---|---|---|---|
| | AVERAGE NUMBER OF CASES | AGE SPECIFIC RATE | AVERAGE NUMBER OF CASES | AGE SPECIFIC RATE | AVERAGE NUMBER OF CASES | AGE SPECIFIC RATE | |
| 15 - 24 | 4.50 | .10 | 1.25 | .03 | 5.75 | .06 | 2.6 |
| 25 - 34 | 32.75 | .70 | 5.50 | .10 | 38.25 | .50 | 17.1 |
| 35 - 44 | 66.75 | 1.50 | 13.75 | .30 | 80.50 | .90 | 36.0 |
| 45 - 54 | 55.25 | 1.40 | 9.00 | .20 | 64.25 | .80 | 28.7 |
| 55 - 64 | 26.00 | .90 | 1.50 | .06 | 27.50 | .50 | 12.3 |
| 65 - 74 | 6.50 | .30 | .25 | .01 | 6.75 | .20 | 3.0 |
| 75 + | .50 | .04 | 0 | 0 | .50 | .02 | .3 |
| TOTALS | 192.25 | | 31.25 | | 223.50 | | |
| Adjusted Rate | | .80 | | .10 | | .50 | |
| Median Age | 43.82 | | 41.46 | | 43.41 | | |

## INDIANS

A special task force was chosen to study the problems of the Indian. It was felt this was necessary since there is a substantial Indian population within Montana still residing in rather large reservation communities. It was not deemed necessary to isolate the Indian to a separate section of the study, since for most situations, the problem of the non-Indian group and of the Indian were essentially the same, and a general discussion of a problem is applicable to both. However, in the area of alcoholic admissions to the State Hospital, there is a significant variation in the Indian group. The following figures consider total first admissions over a four-year period and report an average annual percent of admissions for alcoholism during this period for both the Indian and the non-Indian.

| | Percent Male | Percent Female |
|---|---|---|
| Non-Indian | 35.7 | 10.7 |
| Indian | 57.6 | 25.8 |

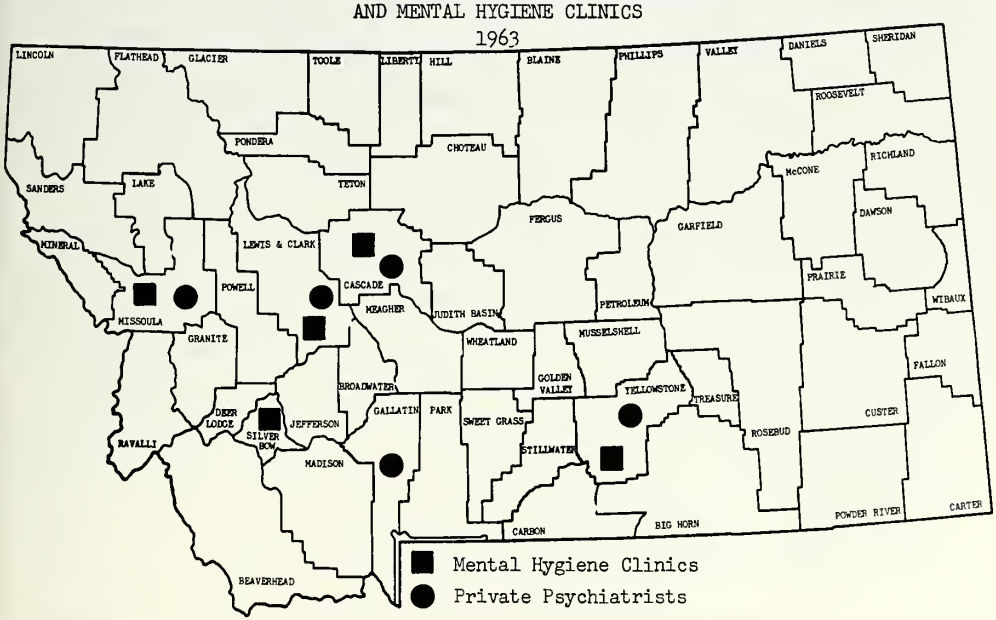
Of all Indians admitted during this period, it is significant that well over half of the males were admitted for reason of alcoholism and over a fourth of the females.

## STATE MENTAL HYGIENE CLINICS

The five state mental hygiene clinics now operative at Billings, Butte, Great Falls, Helena and Missoula were surveyed for the calendar years 1962 and 1963. (See Map 3.1 for locations.) The first admissions for these years total 2,240; 1,161 or 51.8 percent were males, and 1,079 or 48.12 percent were females. (See Table 3.4)

MAP 3.1

LOCATION OF MONTANA PRIVATE PSYCHIATRISTS
AND MENTAL HYGIENE CLINICS
1963




The average rate for the two reporting years, 1962 and 1963, with reference to first admissions into the state mental hygiene clinics has been reported in Table 3.4 for both males and females. Fifty-three percent of the male admissions were under 15 years of age; 33 percent of the female admissions appear in this same age group. Overall, approximately 44 percent of the first admissions into the clinics were in this age group of 0 - 15 years.

It can be readily discerned from study of the age specific rates in Table 3.4 that the patients seen by the state mental hygiene clinics begin to reduce in number markedly in the age group 25 - 34. This trend

TABLE 3.4

STATE MENTAL HYGIENE CLINICS
FIRST ADMISSION AVERAGES 1962-1963
AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION

| AGE GROUP | MALE | | FEMALE | | TOTAL | | TOTAL PERCENT-AGE FOUND IN EACH AGE GROUP |
|---|---|---|---|---|---|---|---|
| | NUMBER OF CASES | AGE SPECIFIC RATE | NUMBER OF CASES | AGE SPECIFIC RATE | NUMBER OF CASES | AGE SPECIFIC RATE | |
| Under 15 yr. | 310.5 | 2.6 | 176.0 | 1.5 | 486.5 | 2.0 | 43.5 |
| 15 to 24 | 125.5 | 2.6 | 155.0 | 3.3 | 280.5 | 3.0 | 25.0 |
| 25 to 34 | 58.5 | 1.4 | 97.0 | 2.3 | 155.5 | 1.8 | 13.9 |
| 35 to 44 | 44.5 | 1.0 | 58.5 | 1.3 | 103.0 | 1.1 | 9.2 |
| 45 to 54 | 29.0 | .7 | 33.0 | .9 | 62.0 | .8 | 5.5 |
| 55 to 64 | 9.0 | .3 | 11.5 | .4 | 20.5 | .4 | 1.8 |
| 65 to 74 | 2.0 | .1 | 6.5 | .3 | 8.5 | .2 | .8 |
| 75 and over | 1.5 | .1 | 2.0 | .2 | 3.5 | .1 | |
| Total | 580.5 | | 539.5 | | 1120.0 | | |
| Adjusted rate | | 1.6 | | 1.6 | | 1.6 | |
| Median age | 14.4 | | 18.7 | | 18.6 | | |

continues in both males and females from this point through the remaining age groups. The populace treated becomes a rather insignificant number in the aged groups.

It is evident then that the clinics are treating a youthful population. Examination of the median ages in the first admissions of males and females reveals them to be respectively 14.4 and 18.7.

A recent study entitled, "A Study of Adolescent Patients in Outpatient Psychiatric Clinics"[1], states that the "outpatient psychiatric clinics in the U.S. serve more persons in the 10 through 19 year age

[1] Beatrice Rosen, Anita K. Bahn, Robert Shellow, and Eli M. Bower, "A Study of Adolescent Patients in Outpatient Psychiatric Clinics". Paper read before the meeting of the American Public Health Association, October 8, 1964 at the session, The Adolescent--Need, Problems, Some Answers.

groups than in any other decade of life".[1,2] The state mental hygiene clinics statistics show that the same pattern exists in Montana.

Chart 3.2 shows the distribution of first admissions to the state mental hygiene clinics by percent in each age group by sex.

## VETERANS

Montana had a male population of 227,197 in the ages from 14 years and older when the 1960 census was taken. Of this group, 89,276 or 39.3 percent were veterans.

From the Montana veteran group, 116 were admitted into a Veterans Hospital as psychiatric patients first admitted during 1963. The Veterans Hospitals to which these patients were admitted are located at Sheridan, Wyoming; Fort Mead, South Dakota; and American Lake, Washington. The hospital at Sheridan admitted the bulk of these patients, having seen 106 or 91 percent of the total. The Fort Mead Hospital admitted six or five percent of the total, and the American Lake Hospital admitted four or four percent.

The age specific rates are understandably higher in the 35 to 54 age groups and the 65 to 74 age groups because those groups represent veterans of the two world wars. (See Table 3.5)

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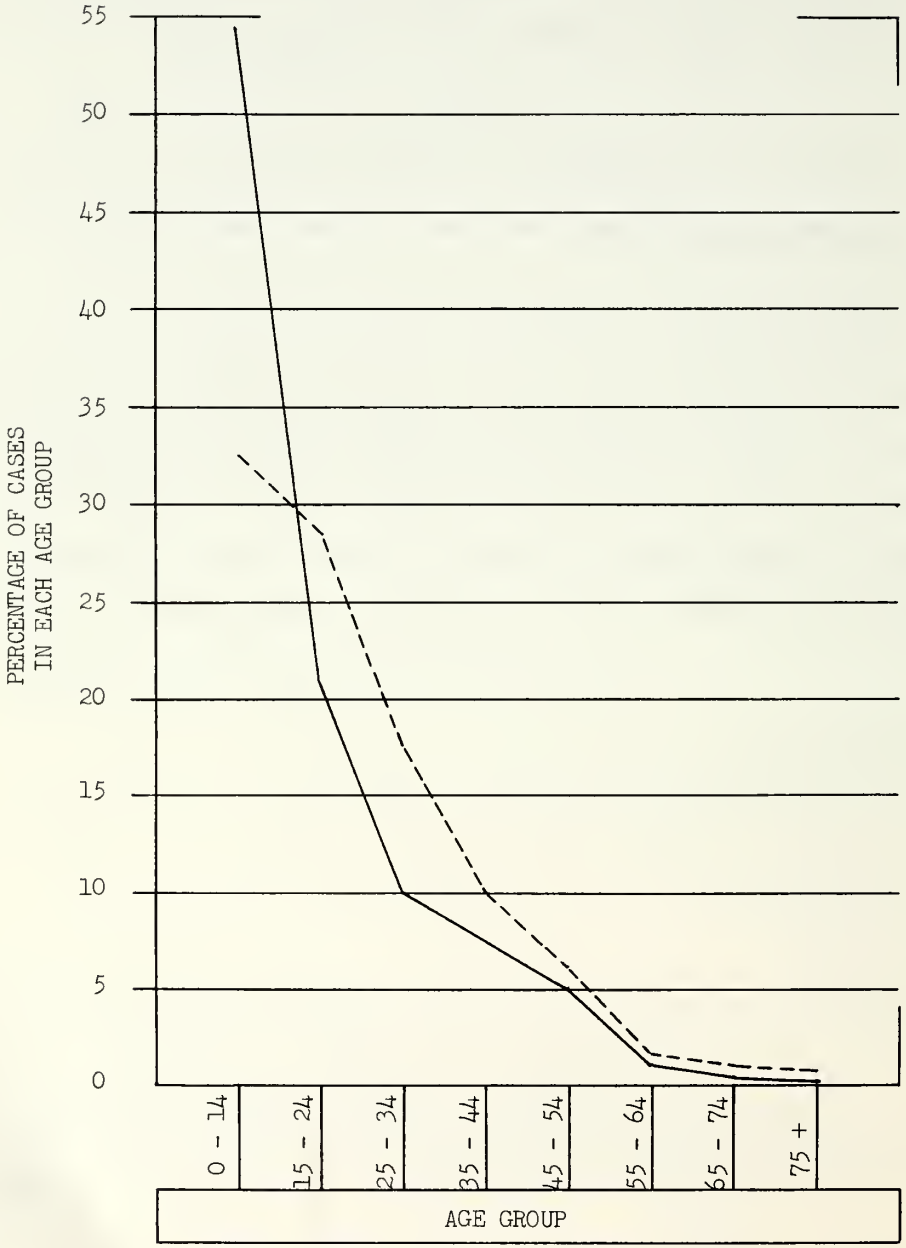
[1] B. M. Rosen, A. K. Bahn, and Mr. Kramer, "Demographic and Diagnostic Characteristics of Psychiatric Clinic Outpatients in the U.S.A., 1961", American Journal of Orthopsychiatry, XXXIV (1964), pp. 455-468.

[2] Outpatient Studies Section, Biometrics Branch; National Institute of Mental Health. Data on patients of outpatient psychiatric clinics in the United States, 1962. (mimeographed)

CHART 3.2

STATE MENTAL HYGIENE CLINICS FIRST ADMISSIONS
PERCENTAGE OF PATIENTS FOUND IN EACH AGE GROUP *




* Based on average admissions for 1962-1963

TABLE 3.5

VETERANS' HOSPITALS
FIRST ADMISSIONS OF MONTANA VETERANS, 1963
AGE SPECIFIC RATES PER 1,000 MONTANA VETERAN POPULATION

| AGE GROUP | MALE | | AGE GROUP | MALE | |
|---|---|---|---|---|---|
| | NUMBER OF CASES | AGE SPECIFIC RATE | | NUMBER OF CASES | AGE SPECIFIC RATE |
| Under 15 | - | - | 45 to 54 | 25 | 2.2 |
| 15 to 24 | 5 | .7 | 55 to 64 | 3 | .4 |
| 25 to 34 | 22 | .8 | 65 to 74 | 14 | 2.1 |
| 35 to 44 | 46 | 1.5 | 75 and over | 1 | 1.1 |
| | | | TOTAL | 116 | - |
| | | | Adjusted Rate | - | 1.3 |
| | | | Median Age | 41.7 | - |

## PRIVATE PSYCHIATRISTS

Eleven private psychiatrists in private practice in Montana in 1963 were invited to participate in this study.[1] Of these 11, nine participated and two declined. The psychiatrists were requested to base the number of cases they reported on the following two criteria: (1) patients seen for the first time during the reporting year (1963); and (2) patients who were legal residents of Montana. (Believing that it would obtain greater cooperation by keeping the volume of data requested to a minimum, the Planning Committee asked only for information respecting age, sex and county of residence.)

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1 Refer to Map 3.1 for location of private psychiatrists.

Converse to the situation existing in the state mental hygiene clinics, there is a very large increase in the private psychiatric case load from the age group under 15 years to the next age group in both males and females in the age specific rates. The number of males seen decreases in the 25 to 34 age group from the preceding age group, remains essentially static in the next, and shows a rather gradual declining situation from this point through the oldest age grouping. The age specific rate for females increases in the 25 to 34 age group, but shows a similar decreasing situation from that point through the remaining age groupings. (See Table 3.6)

TABLE 3.6

PRIVATE PSYCHIATRISTS *
FIRST ADMISSIONS FOR 1963
AGE-SEX SPECIFIC RATES PER 1,000 MONTANA POPULATION

| AGE GROUP | MALE | | FEMALE | | TOTAL | | TOTAL PERCENTAGE FOUND IN EACH AGE GROUP |
|---|---|---|---|---|---|---|---|
| | NUMBER OF CASES | AGE SPECIFIC RATE | NUMBER OF CASES | AGE SPECIFIC RATE | NUMBER OF CASES | AGE SPECIFIC RATE | |
| Under 15 | 39 | .3 | 23 | .2 | 62 | .3 | 4.3 |
| 15 - 24 | 164 | 3.5 | 161 | 3.4 | 325 | 3.4 | 22.6 |
| 25 - 34 | 122 | 2.8 | 210 | 5.0 | 332 | 3.9 | 23.0 |
| 35 - 44 | 132 | 2.9 | 201 | 4.5 | 333 | 3.7 | 23.1 |
| 45 - 54 | 100 | 2.5 | 123 | 3.4 | 223 | 2.9 | 15.5 |
| 55 - 64 | 41 | 1.5 | 51 | 2.0 | 92 | 1.7 | 6.4 |
| 65 - 74 | 23 | 1.0 | 27 | 1.2 | 50 | 1.1 | 3.5 |
| 75 + | 11 | .9 | 13 | 1.1 | 24 | 1.0 | 1.6 |
| TOTALS | 632 | | 809 | | 1441 | | |
| Adjusted Rate | | 1.8 | | 2.3 | | 2.0 | |
| Median Age | 34.26 | | 35.54 | | 35.06 | | |

* Does not include two non-reporting psychiatrists

The median age for patients treated by the private psychiatrists under the previously stipulated criteria was 34.26 for males and 35.54 for females. Generally, the age specific rates were higher in the female group. These findings are presented in Table 3.6.

Based on the aforementioned criteria, during the calendar year 1963, Montana's private psychiatrists saw 1,441 patients in their offices. Of the total number seen, 632 or 43.9 percent were males and 809 or 56.1 percent were females. (Refer to Table 3.6)

## PRIVATE HOSPITALS

Three Montana private hospitals, located at Billings, Great Falls, and Missoula, have psychiatric units. (See Map 4.12, page 76.) All of them cooperated with the project and submitted information with respect to first admissions based on the following criteria: (1) patients seen for the first time during the reporting year 1963; and (2) patients who were legal residents of Montana. Consistent with the questions asked of psychiatrists in private practice, the Planning Committee asked the private hospitals only for information regarding age, sex and place of legal residence.

The ratio of patients in the under 15 years age group seen in the reporting private hospitals is very small in comparison with the other age groupings seen in these hospitals. Most of the patients seen fall in the productive age groups from 16 through 54. The number of cases then decreases rather markedly in the males through age 74 only to rise again in the 75 and over group. The number of female cases begin a gradual tapering off in rate after age group 25 through 34 and becomes increasingly smaller through the remaining age groups. (See Table 3.7)

TABLE 3.7

PRIVATE PSYCHIATRIC HOSPITALIZATION
FIRST ADMISSIONS FOR 1963
AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION

| AGE GROUP | MALE | | FEMALE | | TOTAL | | TOTAL PERCENTAGE FOUND IN EACH AGE GROUP |
|---|---|---|---|---|---|---|---|
| | NUMBER OF CASES | AGE SPECIFIC RATE | NUMBER OF CASES | AGE SPECIFIC RATE | NUMBER OF CASES | AGE SPECIFIC RATE | |
| Under 15 yrs. | 7 | .1 | 5 | .04 | 12 | .05 | 2.3 |
| 15 to 24 | 37 | .8 | 71 | 1.5 | 108 | 1.4 | 20.3 |
| 25 to 34 | 33 | .8 | 89 | 2.1 | 122 | 1.4 | 22.9 |
| 35 to 44 | 26 | .6 | 75 | 1.7 | 101 | 1.2 | 19.0 |
| 45 to 54 | 36 | .9 | 60 | 1.6 | 96 | 1.2 | 18.0 |
| 55 to 64 | 15 | .5 | 37 | 1.4 | 52 | 1.0 | 9.8 |
| 65 to 74 | 8 | .3 | 19 | .9 | 27 | .6 | 5.1 |
| 75 and over | 8 | .7 | 6 | .5 | 14 | .6 | 2.6 |
| Totals | 170 | | 362 | | 532 | | |
| Adjusted rate | | .5 | | 1.0 | | .8 | |
| Median age | 38.08 | | 37.13 | | 37.38 | | |
| | | | | | | | |

The median age for private hospital cases was 38.08 for males and 37.13 for females. The age specific rates were significantly higher for females than males in all but two age groups. The males showed a slightly higher age adjusted rate in age groups under 15, and 75 and over. The lowest age adjusted rates for males and females were found in the age groups under 15, and 65 and over. Table 3.7 presents this information.

Overall, there seems to be a rather insignificant percentage of populace treated in private hospitals in the under 15 years age group, leveling to a fairly static rate through age 64 and then dropping considerably in the age groupings 65 and over.

In the calendar year 1963 the private hospitals received 532 psychiatric first admissions: 170 or 32.0 percent were males and 362 or 68.0 percent were females.

## DIAGNOSTIC GROUPING

Diagnostic information was not obtainable from private treatment sources because private records had not been suitably prepared for research activity. However, public hospitals were able to provide data by diagnosis which is presented in this study. Major diagnostic groupings were selected and presented on Table 3.8 by age and sex of first admissions to Montana State Hospital.[1] This Table presents a four-year average figure for years 1960 through 1963.

The age and sex diagnostic specific rates as presented in Table 3.8 have relatively small numbers of cases in certain diagnostic categories; therefore, these rates should be considered unstable. However, the information is of value in understanding the distribution of first admissions by age, sex, and broad diagnostic categories. Because of the

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[1] American Psychiatric Association, Mental Disorders, Diagnostic and Statistical Manual prepared by the Committee on Nomenclature and Statistics, (Washington, D.C.: American Psychiatric Association, 1952) pp. 78-86. In addition, Montana State Hospital has developed and uses the following codes:

Bland (Unpunched) Diagnosis deferred temporarily

90 Mental disorder undiagnosed
- 90.1x Death of patient prior to diagnosis
- 90.2x Patient left hospital prior to diagnosis
- 90.3x Unknown (old record unavailable or unclear)
- 90.4x Undiagnosed (do not use if some other entry can be made)

91 Without mental disorder
- 91.1x With epilepsy (no psychiatric involvement)
- 91.2x Other physical disorder (no psy. inv.)
- 91.3x All others without mental disorder

92 Miscellaneous
- 92.1x Examination or testing only
- 92.2x Research only

TABLE 3.8

MONTANA STATE HOSPITAL
FIRST ADMISSION FOUR YEAR AVERAGE 1960-1963
AGE-SEX SPECIFIC RATES PER 1,000 MONTANA POPULATION
BY DIAGNOSTIC CATEGORY

| | | MALE | | | | | | | | | FEMALE | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DIAGNOSIS | AGE GROUP | 0-14 | 15-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75 & over | Total | 0-14 | 15-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75 & over | Total |
| Acute Brain Disorder | No. of cases | - | - | 1.00 | 1.00 | 2.25 | 2.00 | .50 | - | 6.75 | - | .25 | - | .75 | .50 | - | .25 | - | 1.75 |
| | Age Spec.Rate | - | - | .02 | .02 | .60 | .07 | .02 | - | - | - | .005 | - | .02 | .01 | - | .01 | - | - |
| Chronic Brain Disorder | No. of cases | 15.75 | 5.50 | 2.75 | 4.50 | 6.50 | 15.50 | 25.75 | 46.50 | 122.75 | 10.25 | 2.50 | 2.75 | 4.00 | 3.75 | 8.75 | 19.25 | 26.75 | 78.00 |
| | Age Spec.Rate | .10 | .10 | .60 | .10 | .20 | .50 | 1.10 | 3.90 | - | .09 | .05 | .07 | .10 | .10 | .30 | .90 | 2.30 | - |
| Psychotic Disorder | No. of cases | 1.25 | 14.00 | 17.25 | 16.50 | 16.25 | 11.75 | 1.75 | .50 | 79.25 | .75 | 12.75 | 18.75 | 16.50 | 18.75 | 7.25 | 2.75 | .25 | 77.75 |
| | Age Spec.Rate | .01 | .30 | .40 | .40 | .40 | .40 | .08 | .04 | - | .006 | .30 | .40 | .40 | .50 | .30 | .10 | .02 | - |
| Psychoneurotic Disorder | No. of cases | .25 | 1.00 | 4.25 | 4.75 | 4.25 | 1.25 | .25 | - | 16.00 | .25 | 5.25 | 5.50 | 8.25 | 6.00 | 4.75 | 2.50 | .25 | 32.75 |
| | Age Spec.Rate | .002 | .02 | .10 | .10 | .10 | .04 | .01 | - | - | .002 | .10 | .10 | .20 | .20 | .20 | .10 | .02 | - |
| Personality Disorder | No. of cases | 4.25 | 35.75 | 52.50 | 80.00 | 57.75 | 25.00 | 4.00 | .25 | 259.50 | .75 | 9.50 | 12.00 | 17.50 | 11.75 | 1.25 | .25 | - | 53.00 |
| | Age Spec.Rate | .04 | .80 | 1.20 | 1.70 | 1.40 | .90 | .20 | .02 | - | .006 | .20 | .30 | .40 | .30 | .05 | .01 | - | - |
| Transient Situational Personality | No. of cases | 2.75 | 4.00 | .50 | .75 | .25 | .75 | .25 | - | 9.25 | 1.50 | 3.00 | 1.25 | .25 | .50 | .75 | .25 | - | 7.50 |
| | Age Spec.Rate | .03 | .08 | .01 | .02 | .006 | .03 | .01 | - | - | .01 | .06 | .03 | .006 | .01 | .03 | .01 | - | - |
| Mental Deficient | No. of cases | 7.50 | 6.00 | 1.00 | 1.75 | 3.25 | .50 | - | - | 20.00 | 3.00 | 3.25 | .50 | 1.00 | .25 | .25 | - | - | 8.25 |
| | Age Spec.Rate | .06 | .10 | .02 | .04 | .08 | .02 | - | - | - | .03 | .07 | .01 | .02 | .007 | .01 | - | - | - |
| Total With Illness | No. of cases | 31.75 | 66.25 | 79.25 | 109.25 | 90.50 | 56.75 | 32.50 | 47.25 | 513.50 | 16.50 | 36.50 | 40.75 | 48.25 | 41.50 | 23.00 | 25.25 | 27.25 | 259.50 |
| | Age Spec.Rate | .30 | 1.40 | 1.90 | 2.40 | 2.30 | 2.00 | 1.40 | 4.00 | - | .10 | .80 | 1.00 | 1.10 | 1.10 | .90 | 1.20 | 2.40 | - |
| Unknown | No. of cases | 1.75 | 2.50 | 1.00 | .75 | 1.50 | .75 | 1.25 | 1.75 | 11.25 | .75 | 1.75 | 1.50 | 1.00 | 1.00 | .75 | .25 | 1.75 | 8.75 |
| | Age Spec.Rate | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Without | No. of cases | - | .25 | - | - | .25 | - | - | - | .50 | - | .25 | - | - | - | - | - | - | .25 |
| | Age Spec.Rate | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| GRAND TOTALS | | 33.50 | 69.00 | 80.25 | 11000 | 92.25 | 57.50 | 33.75 | 49.00 | 525.25 | 17.25 | 38.50 | 42.25 | 49.25 | 42.50 | 23.75 | 25.50 | 29.00 | 268.00 |

relative instability of these rates, only guarded probability statements should be made from these tables.

Chart 3.3 shows the distribution of Montana State Hospital first admission average for years 1960-1963 by percent of patients in each diagnostic grouping by sex.

MONTANA STATE HOSPITAL

First admissions to Montana State Hospital for the reason of alcoholism for a four-year average for males were 192.3 or 36.6 percent, and 32.5 or 11.7 percent for females, with a total of 223.5 or 28.2 percent. Table 3.3 shows a four-year first admission average for all alcoholic diagnoses - age and sex specific rates. (See page 37)

Three diagnostic groups -- acute, chronic, and personality -- received alcoholic first admissions. Of the first admissions to the acute group, 81.5 percent males and 57.2 percent females were admitted with a diagnostic statement containing the word, "alcoholism". In the chronic group there were 6.0 percent males and 4.4 percent females. The personality group had the highest percentage of first admissions for alcoholism -- males represented 69.0 percent and females 52.2 percent of the total admissions to the diagnostic group.

Table 3.9 presents data describing the sources of psychiatric diagnosis and treatment for all reported[1] cases seen as first admissions in 1963. For purposes of this study, two general areas - public and

[1] Public admissions as reported are complete as nearly as can be statistically discerned. However, in the private admissions we must take into consideration that two psychiatrists did not report data for the study, and therefore, a compensating procedure was used as explained in Table 3.9.

CHART 3.3

MONTANA STATE HOSPITAL FIRST ADMISSIONS
PERCENTAGE OF PATIENTS FOUND IN EACH DIAGNOSIS
BY SEX
AVERAGE FOR YEARS 1960-1963

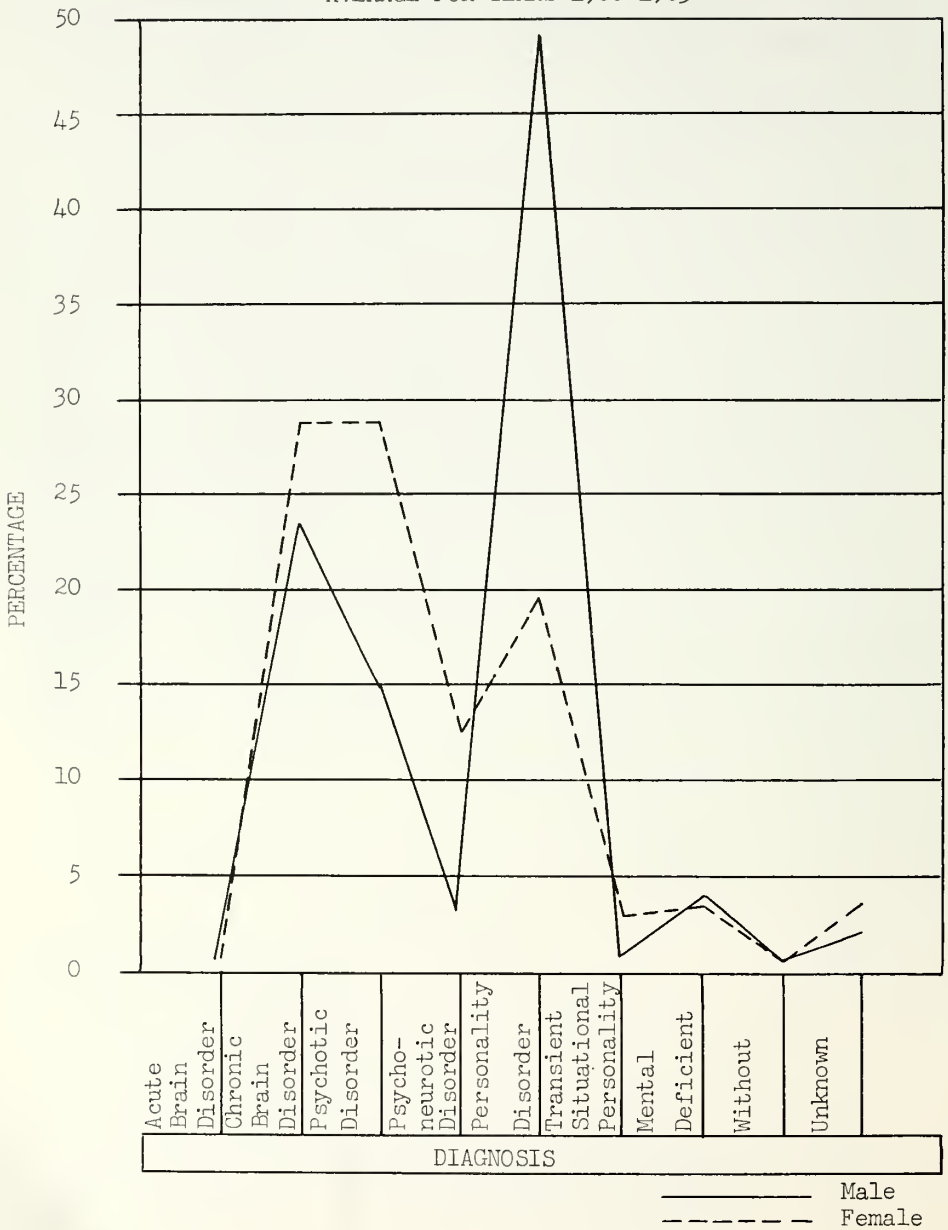


TABLE 3.9

TOTAL FIRST ADMISSIONS MONTANA RESIDENTS
INTO PUBLIC AND PRIVATE TREATMENT
BY FACILITY AND SEX 1963

SECTION A.

| PUBLIC TREATMENT | | FIRST ADMISSIONS MALE | FIRST ADMISSIONS FEMALE | % OF 1ST ADMS. INTO PUB FACILITY BY SEX | TOTAL FIRST ADMS. | % OF TOTAL PUBLIC ADMS. |
|---|---|---|---|---|---|---|
| Montana State Hospital | Male | 505 | | 66.0 | 765 | 36.8 |
| | Female | | 260 | 34.0 | | |
| Mental Hygiene Clinics | Male | 616 | | 51.3 | 1200 | 57.6 |
| | Female | | 584 | 48.7 | | |
| Veterans Hospitals | Male | 116 | | 100.0 | 116 | 5.6 |
| | Female | | 0 | | | |
| Total Public Adms. | | 1237 | 844 | | 2081 | 100.0 |
| PRIVATE TREATMENT | | FIRST ADMISSIONS MALE | FIRST ADMISSIONS FEMALE | % OF 1ST ADMS. INTO PRI FACILITY BY SEX | TOTAL FIRST ADMS. | % OF TOTAL PRIVATE ADMS. |
| Private Psychiatrists | Male | 632 | | 43.9 | 1441 | 73.0 |
| | Female | | 809 | 56.1 | | |
| Private Hospitals | Male | 170 | | 32.0 | 532 | 27.0 |
| | Female | | 362 | 68.0 | | |
| Total Private Adms. | | 802 | 1171 | | 1973 | |

SECTION B.

| TOTAL PUBLIC AND PRIVATE TREATMENT | | | |
|---|---|---|---|
| Public | Sex | Adms. | % of Total |
| | Male | 1237 | 59.4 |
| | Female | 844 | 40.6 |
| | Total | 2081 | 100.0 |
| Private | Male | 802 | 40.6 |
| | Female | 1171 | 59.4 |
| | Total | 1973 | 100.0 |
| Total | Male | 2039 | 50.3 |
| | Female | 2015 | 49.7 |
| GRAND TOTAL | | 4054 | 100.0 |
| Public Treatment | | 2081 or 51.3 | |
| Private Treatment | | 1973 or 48.7 | |

Table 3.11, Section A is basically indicative of the following factors with relation to first admissions into either public or private treatment: numbers seen by sex and facility; percentage of admissions each sex accounts for into listed facility; the total first admissions (male and female) into each listed facility; the percent which the total first admission number from any one listed facility is of the total number of admissions into that treatment source, i.e., public or private.

Section B indicates: total number admitted to treatment source; percent each number is of total admissions; and total number admitted to public and private sources and percentage each represents of all first admissions into any source.

private - are designated as providing psychiatric treatment. Each area is considered separately to determine how many patients are treated by tax-initiated and supported agencies, and how many are treated in wholly private facilities. Other studies of state incidence rates have generally included only those cases seen by public

agencies. Incorporation in state rates of the number of patients seen by private Montana facilities will certainly lend more meaning to such a study, particularly in view of the fact that almost half of all first admissions were privately seen.

The distribution of the 4,054 persons seen as first admissions for psychiatric diagnosis and treatment in 1963 is presented in Table 3.9. The public agencies treated 2,081 cases, or 51.3 percent of the total. Private facilities treated 1,973 cases or 48.7 percent of the total. Private psychiatrists in their office practice treated 1,441 or 35.5 percent of all patients seen -- the largest of any treatment source. Of the total first admissions into any source in 1963, the veterans' hospitals saw the fewest, having seen only 116 or 2.9 percent of the total.

At this point it is helpful to isolate two general areas of study, i.e., public and private, and report on the case load of each treatment agent with respect to the percent of the load carried within its area.

As indicated on Table 3.9, the public agencies include: Montana State Hospital, located at Warm Springs, Montana; state mental hygiene clinics, five locations as described on page 38; and the veterans hospitals located at Sheridan, Wyoming; Fort Mead, South Dakota; and American Lake, Washington. These agencies were surveyed for Montana residents first admissions for the year 1963. Of the 2,081 seen, the state mental hygiene clinics saw 1,200 or 57.6 percent of the total. Montana State Hospital saw 765 or 36.8 percent, and the veterans hospitals saw 116 or 5.6 percent of the total.

Of the total admissions into public facilities, 1,237 or 59.4 percent were males and 844 or 40.6 percent were females.

The private facilities surveyed include private psychiatrists and private hospitals. (See pages 43 and 45) There are no psychologists or psychiatric social workers in full-time private practice in Montana. The reporting criteria for private facilities was similar to that of the public agencies. Of the total of 1,973 patients, 1,441 or 73 percent were seen by the private psychiatrists. The private hospitals saw 532 or 27 percent of this group. Again, considering all private facility admissions as an entity, it is notable that 802 or 40.6 percent of the admissions were males and 1,171 or 59.4 percent were females. The private facility admissions for males and females show a conversely identical situation in the percentages seen in public facilities. Noting that a considerable number of the public admission males were alcoholic creates a somewhat exaggerated situation; however, the public male rate remains higher than the private even if the male alcoholics are excluded. A compensating number for the two psychiatrists who did not contribute data to the study has been added into the rates for private psychiatrists in Table 3.10. The average number of patients seen by the psychiatrists cooperating in the study was calculated, and this average was assigned to the two non-reporting psychiatrists. The average for the non-reporting private psychiatrists was added to the participating psychiatrists in the study; this study is included in Table 3.10. By comparing Table 3.9 with Table 3.10, it should be noted that with the addition of the compensating numbers for the two non-reporting psychiatrists, the number of patients seen is greater for private than for public treatment.

TABLE 3.10

TOTAL FIRST ADMISSIONS MONTANA RESIDENTS*
INTO PUBLIC AND PRIVATE TREATMENT
BY FACILITY AND SEX, 1963

| SEX | PUBLIC | | | PRIVATE | |
|---|---|---|---|---|---|
| | MONTANA STATE HOSPITAL | MENTAL HYGIENE CLINICS | VETERANS HOSPITALS | PRIVATE PSYCHIA-TRISTS | PRIVATE HOSPITALS |
| Male | 561 | 616 | 116 | 772 | 170 |
| Female | 274 | 584 | 0 | 989 | 362 |
| TOTALS | 835 | 1200 | 116 | 1761 | 532 |
| GRAND TOTALS | 2151 | | | 2293 | |
| PERCENTAGE | 48.4% | | | 51.6% | |

* It is important that the numbers as reported under Private Psychiatrists are interpreted as being only suggestive of the number of patients the non-reporting psychiatrist may have seen. However, we know that a number of patients were seen by them and assigning an overall average seems to be an equitable method from which to derive information necessary to arrive at a more accurate number of patients admitted into treatment by private psychiatrists. The table should, therefore, be considered informative and useful when utilized in the awareness of its limitations.

Examination of the age specific rates on Table 3.11 reveals that the youth (under 15) and the aged (75 and over) are treated mostly at a public treatment source. This is particularly true in the under 15 group where we find that 87 percent of the patients seen in this age group were admitted to a public treatment source.

Treatment of males during the productive years (16-64) appears almost equal for either public or private sources. However, in this same productive age grouping, it is noteworthy that nearly twice as many females were seen by private sources.

While it cannot be definitively concluded that the male patient more likely will be treated at a public treatment source,

TABLE 3.11

AGE-SEX SPECIFIC RATES OF MENTAL ILLNESS
BY SOURCE OF TREATMENT PER 1,000 MONTANA POPULATION
1963

| AGE GROUP | MALE | | | | FEMALE | | | | TOTAL | | | | TOTAL ALL CASES | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | PUBLIC | | PRIVATE | | PUBLIC | | PRIVATE | | PUBLIC | | PRIVATE | | | |
| | NO. OF CASES | AGE SPEC. RATE | NO. OF CASES | AGE SPEC. RATE | NO. OF CASES | AGE SPEC. RATE | NO. OF CASES | AGE SPEC. RATE | NO. OF CASES | AGE SPEC. RATE | NO. OF CASES | AGE SPEC. RATE | NO. OF CASES | AGE SPEC. RATE |
| Under 15 yrs. | 364 | 3.0 | 46 | .4 | 206 | 1.8 | 28 | .2 | 570 | 2.4 | 74 | .3 | 644 | 15.9 |
| 15 - 24 | 219 | 4.6 | 201 | 4.2 | 219 | 4.6 | 232 | 4.9 | 438 | 4.6 | 433 | 4.5 | 871 | 21.5 |
| 25 - 34 | 175 | 4.1 | 155 | 3.6 | 140 | 3.3 | 299 | 7.1 | 315 | 3.7 | 454 | 5.4 | 769 | 19.0 |
| 35 - 44 | 177 | 3.8 | 158 | 3.4 | 97 | 2.2 | 276 | 6.2 | 274 | 3.0 | 434 | 4.8 | 708 | 17.5 |
| 45 - 54 | 145 | 3.6 | 136 | 3.4 | 78 | 2.1 | 183 | 5.0 | 223 | 2.9 | 319 | 4.2 | 542 | 13.3 |
| 55 - 64 | 53 | 1.9 | 56 | 2.0 | 39 | 1.5 | 88 | 3.4 | 92 | 1.7 | 144 | 2.7 | 236 | 5.8 |
| 65 - 74 | 52 | 2.2 | 31 | 1.3 | 26 | 1.2 | 46 | 2.1 | 78 | 1.7 | 77 | 1.7 | 155 | 3.8 |
| 75 and over | 52 | 4.4 | 19 | 1.6 | 39 | 3.4 | 19 | 1.7 | 91 | 3.9 | 38 | 1.6 | 129 | 3.2 |
| TOTALS | 1237 | | 802 | | 844 | | 1171 | | 2081 | | 1973 | | 4054 | |
| Adjusted Rate | | 3.4 | | 2.2 | | 2.4 | | 3.4 | | 2.9 | | 2.8 | | 6.0 |

significant that the age specific rates are higher for males in all age groups of public treatment, with the single exception of group 55 - 64 where the difference in rates was only very slight. On the other hand, there is basis for valid assumption that in many of the female age groupings, most of the case load would be cared for by private practitioners.

Finally, there is conclusive evidence that there were approximately six people admitted to first-time psychiatric treatment sources of either public or private nature for every 1,000 people in Montana's populace during the 1963 calendar year.

## MENTAL HYGIENE CLINICS

The five state mental hygiene clinics were studied for the two-year period previously mentioned (1962-1963). The computed average rate of admissions per year indicated that there were 580.5 males and 539.5 females, or a total of 1,120 patients admitted into the clinics on a first-time basis.

Table 3.12 gives a breakdown by age and diagnosis of these 1,120 admissions. The large number of patients found in either the undiagnosed or deferred categories merits an explanation of cause. In these instances, a diagnosis was not available on the IBM data card since it is the procedure of the clinics not to record a diagnosis on the patient until the case is closed. At the time of closing, a diagnosis is then recorded and reported on the data card.

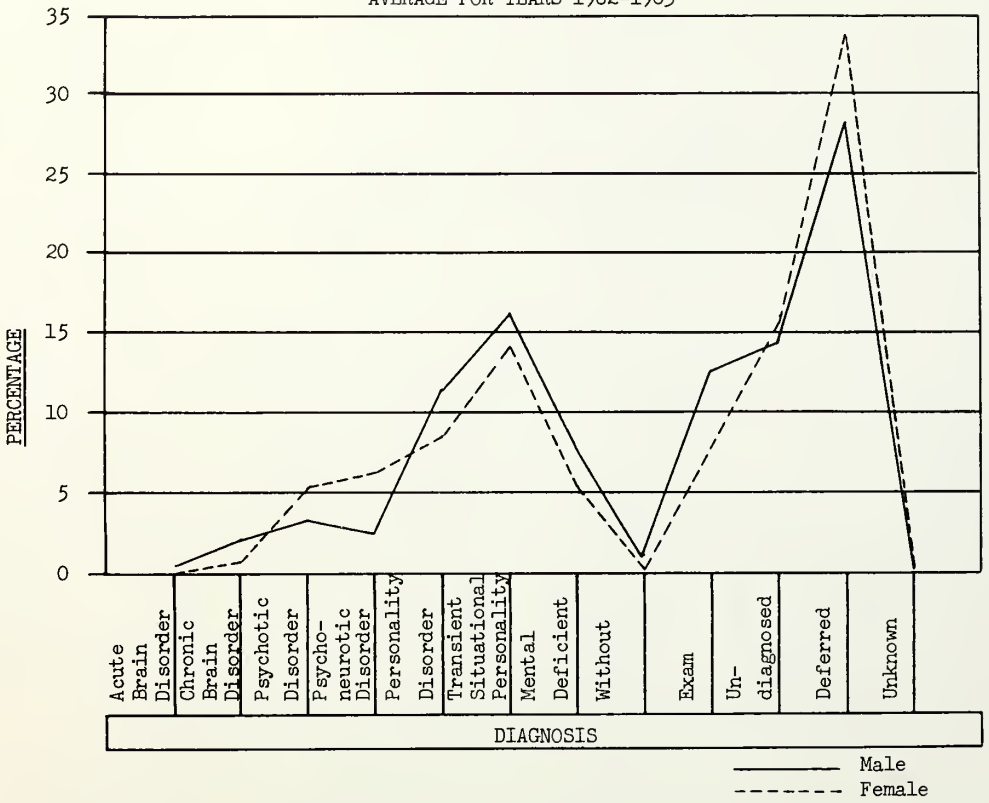
Of those cases diagnosed and recorded, a similar pattern prevails in the number of cases found in each diagnostic group in both males and females. (See Chart 3.4) The greatest variation is found in the psychoneurotic group in which the female percentage remains rather high while the percentage of males tends to be lower. In this group for which diagnosis has been given, the majority of the cases are found in the personality disorder categories which would include the specific diagnoses of personality disorders and transient situational personality disorders. For the females, the next largest number in a diagnosis is found in the psychoneurotic group. Mental deficiency is a rather significant diagnosis in both sexes and commands the next largest number

TABLE 3.12
MENTAL HYGIENE CLINICS
FIRST ADMISSION TWO YEAR AVERAGE 1962-1963
AGE-SEX SPECIFIC RATES PER 1,000 MONTANA POPULATION
BY DIAGNOSTIC CATEGORY

| | | MALE | | | | | | | | | FEMALE | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| DIAGNOSIS | AGE GROUP | 0-14 | 15-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75 & over | Total | 0-14 | 15-24 | 25-34 | 35-44 | 45-54 | 55-64 | 65-74 | 75 & over | Total |
| Acute Brain | No. of cases | 1.00 | - | - | - | - | - | - | - | 1.00 | - | - | - | - | - | - | - | - | - |
| Disorder | Age Spec.Rate | .008 | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - | - |
| Chronic Brain | No. of cases | 6.50 | - | 1.50 | 1.00 | 2.00 | 1.50 | .50 | .50 | 13.50 | 4.50 | - | - | 1.00 | - | - | - | - | 5.50 |
| Disorder | Age Spec.Rate | .05 | - | .04 | .02 | .05 | .05 | .02 | .04 | - | .04 | - | - | .02 | - | - | - | - | - |
| Psychotic | No. of cases | 1.50 | 6.50 | 4.00 | 2.00 | 3.00 | 1.50 | - | - | 18.50 | 1.00 | 8.00 | 6.00 | 4.50 | 4.00 | 4.00 | 1.00 | - | 28.50 |
| Disorder | Age Spec.Rate | .01 | .10 | .10 | .04 | .07 | .05 | - | - | - | .008 | .20 | .10 | .10 | .10 | .20 | .05 | - | - |
| Psycho-neurotic | No. of cases | 1.50 | 5.50 | 4.50 | 1.00 | .50 | 1.00 | .50 | - | 14.50 | 1.00 | 10.50 | 8.00 | 5.00 | 6.00 | 1.00 | 1.50 | - | 33.00 |
| Disorder | Age Spec.Rate | .01 | .10 | .10 | .02 | .01 | .04 | .02 | - | - | .008 | .20 | .20 | .10 | .20 | .04 | .07 | - | - |
| Personality | No. of cases | 25.50 | 22.00 | 6.00 | 6.50 | 3.00 | 1.00 | .50 | - | 64.50 | 11.00 | 21.50 | 7.50 | 3.00 | 2.00 | .50 | - | - | 45.50 |
| Disorder | Age Spec.Rate | .20 | .50 | .10 | .10 | .07 | .04 | .02 | - | - | .10 | .50 | .20 | .07 | .05 | .02 | - | - | - |
| Transient Situational | No. of cases | 60.50 | 13.50 | 7.00 | 8.00 | 4.50 | .50 | .50 | - | 94.50 | 25.00 | 27.50 | 13.00 | 7.50 | 3.00 | - | - | - | 76.00 |
| Personality | Age Spec.Rate | .50 | .30 | .20 | .20 | .10 | .02 | .02 | - | - | .20 | .60 | .30 | .20 | .08 | - | - | - | - |
| Mental | No. of cases | 37.00 | 3.50 | 1.50 | 1.00 | - | - | - | .50 | 43.50 | 25.50 | 2.50 | 1.50 | 1.00 | - | .50 | - | - | 31.00 |
| Deficient | Age Spec.Rate | .30 | .07 | .04 | .02 | - | - | - | .04 | - | .20 | .05 | .04 | .02 | - | .02 | - | - | - |
| Without Mental | No. of cases | 4.00 | 1.00 | - | - | .50 | - | - | - | 5.50 | 1.50 | .50 | .50 | - | .50 | - | - | - | 3.00 |
| Disorder | Age Spec.Rate | .03 | .02 | - | - | .01 | - | - | - | - | .01 | .01 | .01 | - | .01 | - | - | - | - |
| Exam | No. of cases | 49.00 | 12.00 | 7.50 | 2.50 | 2.00 | .50 | - | - | 73.50 | 26.00 | 10.00 | 7.00 | 3.50 | 1.00 | .50 | - | - | 48.00 |
| | Age Spec.Rate | .40 | .30 | .20 | .05 | .05 | .02 | - | - | - | .20 | .20 | .20 | .08 | .03 | .02 | - | - | - |
| Undiagnosed | No. of cases | 49.00 | 18.00 | 8.00 | 5.50 | 2.00 | 1.50 | - | .50 | 84.50 | 38.00 | 16.00 | 12.50 | 8.50 | 4.00 | 1.50 | 1.50 | 2.00 | 84.00 |
| | Age Spec.Rate | .40 | .40 | .20 | .10 | .05 | .05 | - | .40 | - | .30 | .30 | .30 | .20 | .10 | .06 | .07 | .20 | - |
| Deferred | No. of cases | 74.50 | 42.50 | 18.50 | 17.00 | 11.00 | 1.50 | - | - | 165.00 | 42.00 | 58.00 | 41.00 | 24.50 | 12.50 | 3.50 | 2.50 | - | 184.00 |
| | Age Spec.Rate | .60 | .90 | .40 | .40 | .30 | .05 | - | - | - | .40 | 1.20 | 1.00 | .60 | .30 | .10 | .10 | - | - |
| Unknown | No. of cases | .50 | 1.00 | - | - | .50 | - | - | - | 2.00 | .50 | .50 | - | - | - | - | - | - | 1.00 |
| | Age Spec.Rate | .004 | .04 | - | - | .01 | - | - | - | - | .004 | .01 | - | - | - | - | - | - | - |
| TOTAL | | 310.50 | 125.50 | 58.50 | 44.50 | 29.00 | 9.00 | 2.00 | 1.50 | 580.50 | 176.00 | 155.00 | 97.00 | 58.50 | 33.00 | 11.50 | 6.50 | 2.00 | 539.50 |

CHART 3.4

MENTAL HYGIENE CLINICS FIRST ADMISSIONS
PERCENTAGE OF PATIENTS FOUND IN EACH DIAGNOSIS*
BY SEX
AVERAGE FOR YEARS 1962-1963



of patients.[1]

The designation "Without" as shown on Chart 3.4 is the dividing point between those patients having received a diagnosis and those for which a diagnosis has not yet been reported. All designations to the right are indicative of patients who do not have a reported diagnosis. Those patients having a diagnosis reported represent 44.1 percent of the males and 41.3 percent of the females. The remainder of the patients admitted are in the group for which a diagnosis has not been reported.

[1]The trends indicated in this paragraph coincide with those reported in a much broader study done in 1962 by the National Institute of Mental Health in which 788 outpatient psychiatric clinics were surveyed with respect to problems of the adolescent.
A. K. Bahn, Eli M. Bower, Beatrice Rosen and Robert Shellow, "A Study of Adolescent Patients Served in Outpatient Psychiatric Clinics"; (a paper), presented at American Public Health Association Meeting, October 8, 1964.

CHAPTER IV

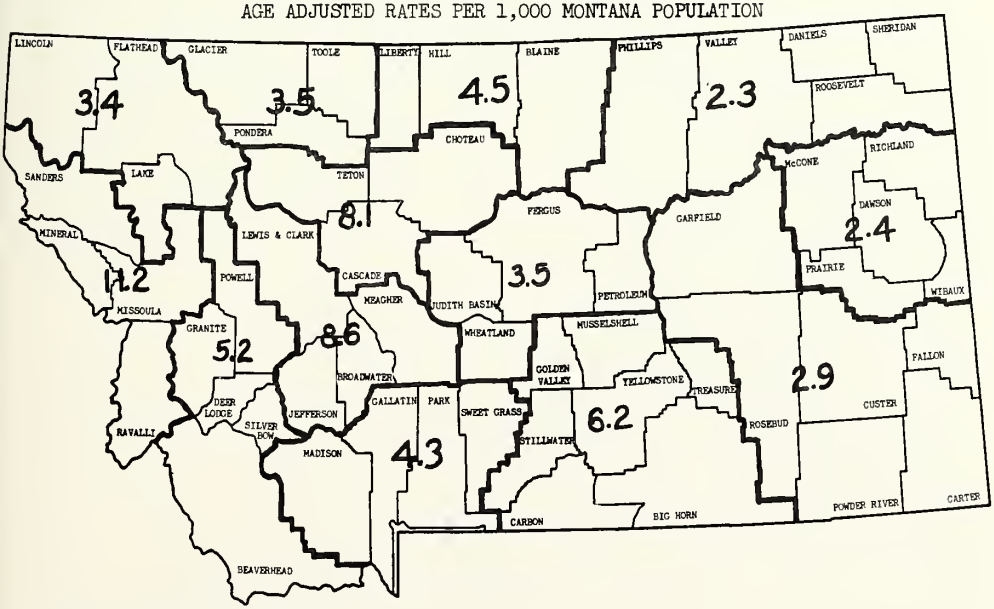
## THE SPATIAL DISTRIBUTION OF MENTAL ILLNESS

All 56 counties during the period of this study exhibited cases. However, a great many counties had only a few cases in any one year. To facilitate collection of data and to make the rates in the state more easily comparable, the 56 counties were incorporated into 13 "administrative" districts selected on the basis of their areas of trade, socio-economic, political interests, service areas, distance of travel, highway accessibility, and transportation systems.[1]

Map 4.1 indicates total incidence rates for each of the 13 administrative districts described.

MAP 4.1

TOTAL INCIDENCE OF FIRST ADMISSIONS 1963
BY 13 ADMINISTRATIVE DISTRICTS
INTO ALL TREATMENT FACILITIES
AGE ADJUSTED RATES PER 1,000 MONTANA POPULATION




[1] See Appendix A, Map I.

The reported rates are inclusive of all first admissions into all known treatment resources in Montana and veteran facilities in Wyoming, South Dakota, and Washington.

Utilizing these data, the 13 administrative districts were adjusted for age and sex, and the resultant rates are reported in Table 4.1.

TABLE 4.1

TOTAL INCIDENCE OF FIRST ADMISSIONS 1963
BY ADMINISTRATIVE DISTRICTS
INTO ALL TREATMENT FACILITIES
AGE-SEX ADJUSTED RATES PER 1,000 MONTANA POPULATION

| DISTRICT | SEX | | OVERALL |
|---|---|---|---|
| | MALE | FEMALE | |
| 1 | 4.4 | 2.3 | 3.4 |
| 2 | 3.3 | 3.7 | 3.5 |
| 3 | 4.0 | 5.0 | 4.5 |
| 4 | 2.2 | 2.5 | 2.3 |
| 5 | 2.9 | 2.0 | 2.4 |
| 6 | 3.8 | 3.1 | 3.5 |
| 7 | 6.9 | 9.4 | 8.1 |
| 8 | 8.8 | 8.3 | 8.6 |
| 9 | 5.3 | 5.1 | 5.2 |
| 10 | 10.4 | 12.1 | 11.2 |
| 11 | 4.8 | 3.8 | 4.3 |
| 12 | 6.6 | 5.9 | 6.2 |
| 13 | 3.4 | 2.4 | 2.9 |

Generally speaking, it can be stated that the lowest rates are found in the highly rural areas, as evidenced in the northern and eastern districts of the state; the higher rates are located in areas that include well-established urban centers.

It is important to consider factors other than population which contribute to high incidence rates exhibited by populous areas of the state. By isolating treatment resources, it is possible to partially determine the effect that a particular type of treatment facility has on a given district of the state. If admissions alone into Montana State Hospital were considered, District No. 9 would appear to be the most problematical area in Montana. However, considering the close correlation between distance and number of persons admitted into the Hospital, it comes as no surprise that the district in which Montana State Hospital is located has a high rate if the Hospital admission records are considered without considering other factors.

The location of state mental hygiene clinics gives a different impression of district admission rates. District No. 9, although still high by comparison with many of its compeers, now does not appear to have extreme rates. The admission rates now are higher in District No. 10. However, District No. 9 provides some competition. Generally, it could be stated without equivocation that the clinics are an extremely valuable source of aid to Montana's citizenry. The higher admission rates found in areas of clinic locale are indicative of the fact that if the service is provided, people will avail themselves of that service just as they would of any other professional facility. Those who would postulate that clinics create incidence must realize that need creates

service - service creates usage - usage creates higher admission rates. It is well recognized that clinics play an eminent part in prevention of mental illness and are responsible for reducing the need for long tenure in the State Hospital.

If the cases seen only by private psychiatrists are reviewed, District No. 7 emerges as the greatest source of the mentally disturbed. Districts No. 10, 11 and 12 likewise appear high on the scale of the problematical. Again, the areas in which certain services are available, show the highest incidence of admission.

Examination of admissions into private hospitals only show Districts No. 7 and 10 high above the rest; but again, this impression is contingent upon the fact that in each of these districts is located one of the three private Montana hospitals which admit psychiatric patients for treatment.

Veteran admissions put up a strong case for the premise that the nearer the district is to the treatment facility, the greater its chances of having a high rate. This, however, is not entirely true since higher rates are exhibited in the extreme western and northern districts than in the middle western districts.

The following general statement is valid when applied to any of the described situations: the greater the treatment resource in any given area, the greater the patient load originating from that district and thus the greater the incidence appears to be. However, there is no reason to assume that incidence is created by the presence of a treatment facility.

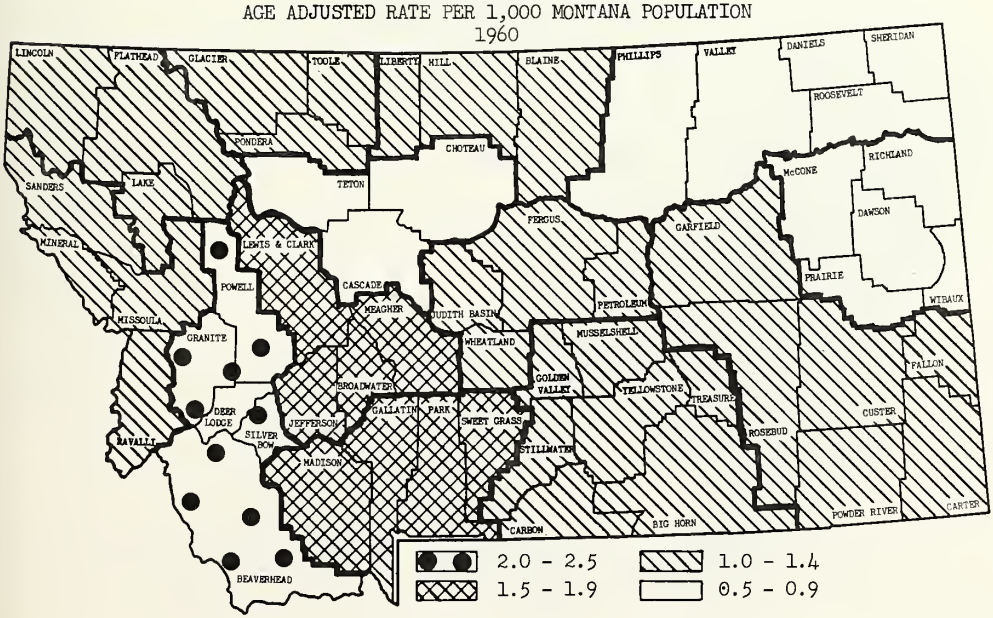
Consideration of the total incidence rates per 1,000 Montana population (as portrayed on Map 4.1) indicates that the higher rates are again found in those districts that provide services to its populace. These rates result from the consideration of all first admissions for the year 1963 into the previously named facilities, i.e., Montana State Hospital, mental hygiene clinics, private psychiatrists, private hospitals, and veterans hospitals.

## MONTANA STATE HOSPITAL

Maps 4.2, 4.3, 4.4, and 4.5 illustrate for years 1960-1963 the distribution of the age adjusted rates by the 13 administrative districts for first admissions to Montana State Hospital.

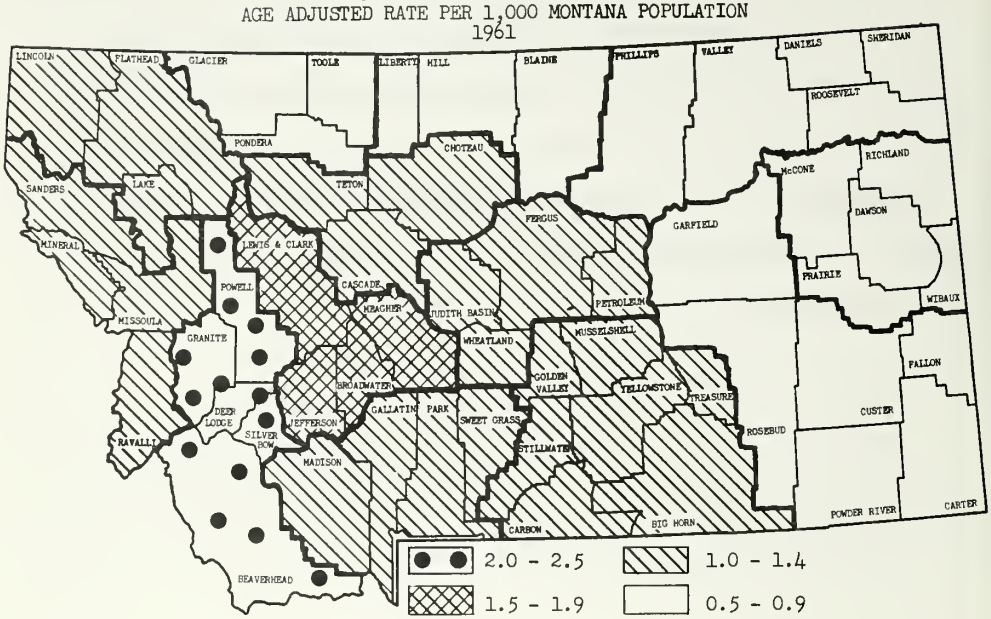
MAP 4.2

FIRST ADMISSIONS MONTANA STATE HOSPITAL
13 ADMINISTRATIVE DISTRICTS
AGE ADJUSTED RATE PER 1,000 MONTANA POPULATION
1960



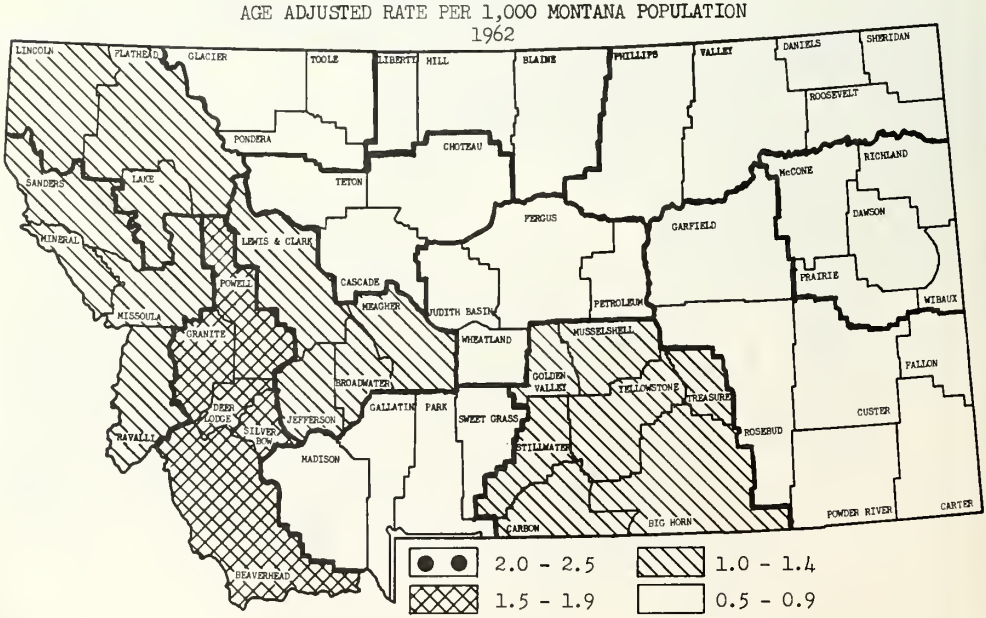
MAP 4.3

FIRST ADMISSIONS MONTANA STATE HOSPITAL
13 ADMINISTRATIVE DISTRICTS
AGE ADJUSTED RATE PER 1,000 MONTANA POPULATION
1961



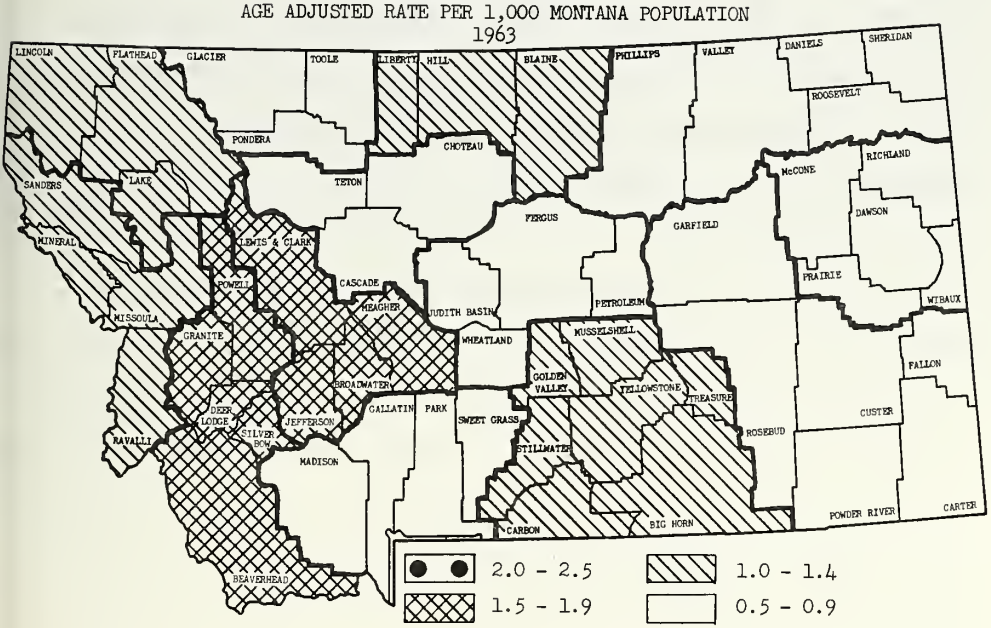

MAP 4.4

FIRST ADMISSIONS MONTANA STATE HOSPITAL
13 ADMINISTRATIVE DISTRICTS
AGE ADJUSTED RATE PER 1,000 MONTANA POPULATION
1962



MAP 4.5

FIRST ADMISSIONS MONTANA STATE HOSPITAL
13 ADMINISTRATIVE DISTRICTS
AGE ADJUSTED RATE PER 1,000 MONTANA POPULATION
1963




A high correlation was found between crude and adjusted rates[1] for the 13 districts. This close agreement indicates that the characteristics of age and sex do not significantly alter the state's distribution of the first admissions to Montana State Hospital.

For three of the four years included in the study, we find that District No. 9 had the highest rate in the state; in the fourth year, it tied with District No. 8 for first place. The year 1961 exhibited

[1]For detailed information of crude and adjusted rates see Pauline V. Young, Ph.D., Scientific Social Surveys & Research, (N.J.; Prentice Hall, Inc., 1956), pp. 429-435.

a decreasing situation in rates from the previous year: eight of the 13 districts had declining rates; two remained static; and three showed increases. In 1962 there were eight districts with rates declining, four static, and one with increased rates; 1963 indicated a general upswing, having seven districts with increases, four static, and only two showing decreases. (See Table 4.2)

By ranking the 13 districts, we find that the districts individually do not show much variation from 1960 to 1963. There is a high rank order correlation of .79 which is at the one percent level of significance.

A Pearson correlation coefficient (r) of .41 was obtained between age adjusted first admission rates to Montana State Hospital and distance from county seats.[1] This correlation indicates a relationship between first admissions and availability of Montana State Hospital services. However, this correlation does not reflect need in any given area of the state. In general, the greater the distance an individual lives from the services, the less likely he will be able to avail himself of the service although a need may exist.

Map 4.6 indicates spatial distribution for the 13 districts by an average annual rate per 1,000 Montana population into Montana State Hospital. This average is based on the first admissions to the Hospital for the calendar years 1960-1963.

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[1] Significant at the one percent level of confidence.

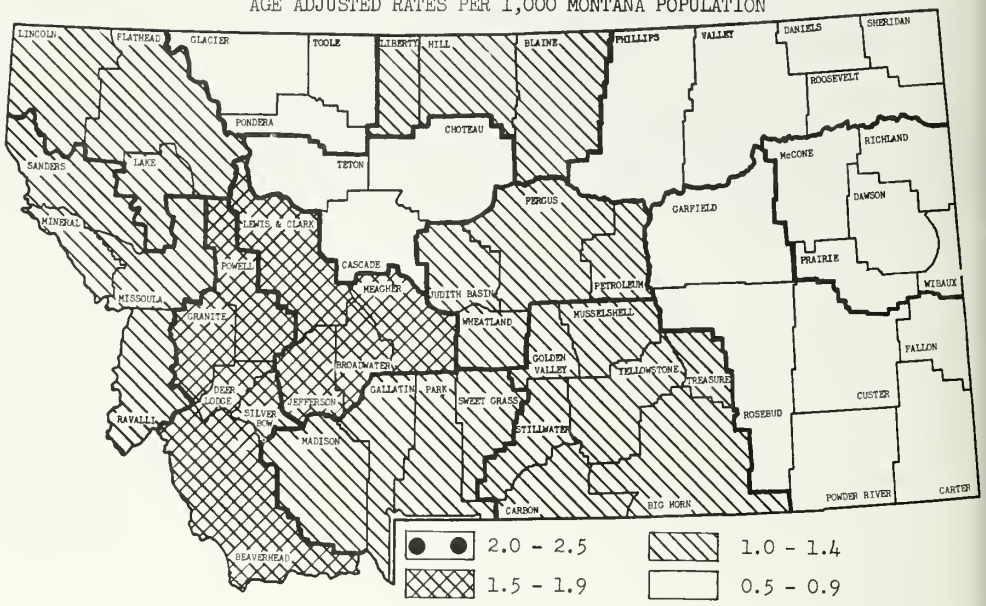
TABLE 4.2

FIRST ADMISSIONS TO
MONTANA STATE HOSPITAL
13 ADMINISTRATIVE DISTRICTS
AGE-SEX ADJUSTED RATES PER 1,000 MONTANA POPULATION

| DIST-RICT NAME | 1960 | | | 1961 | | | 1962 | | | 1963 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | MALE | FEMALE | OVERALL | MALE | FEMALE | OVERALL | MALE | FEMALE | OVERALL | MALE | FEMALE | OVERALL |
| 1 | 1.5 | .8 | 1.1 | 2.0 | .9 | 1.4 | 1.3 | .8 | 1.1 | 1.5 | .5 | 1.0 |
| 2 | 1.5 | .6 | 1.1 | 1.4 | .4 | .9 | .9 | .9 | .9 | 1.1 | .7 | .9 |
| 3 | 1.2 | 1.2 | 1.2 | .9 | .8 | .9 | 1.2 | .6 | .9 | 1.1 | 1.1 | 1.1 |
| 4 | 1.1 | .7 | .9 | 1.1 | .7 | .9 | .6 | .8 | .7 | .9 | .7 | .8 |
| 5 | .6 | .9 | .8 | .8 | .6 | .7 | 1.1 | .7 | .9 | 1.1 | .7 | .9 |
| 6 | 1.5 | .8 | 1.1 | 1.9 | .7 | 1.3 | 1.1 | .6 | .8 | 1.2 | .5 | .9 |
| 7 | 1.2 | .5 | .9 | 1.3 | .6 | 1.0 | 1.1 | .5 | .8 | .9 | .6 | .8 |
| 8 | 2.1 | 1.6 | 1.9 | 2.6 | .8 | 1.7 | 1.6 | 1.0 | 1.3 | 2.4 | 1.2 | 1.8 |
| 9 | 3.0 | 1.6 | 2.3 | 2.7 | 1.2 | 2.0 | 2.1 | 1.4 | 1.8 | 2.4 | 1.2 | 1.8 |
| 10 | 2.0 | .7 | 1.4 | 1.6 | .8 | 1.2 | 1.5 | .8 | 1.2 | 1.7 | .8 | 1.3 |
| 11 | 2.4 | .7 | 1.6 | 1.7 | .4 | 1.1 | 1.0 | .5 | .8 | 1.2 | .4 | .8 |
| 12 | 1.3 | .7 | 1.1 | 1.4 | .8 | 1.1 | 1.3 | .6 | 1.0 | 1.3 | .7 | 1.0 |
| 13 | 1.1 | .8 | 1.0 | .9 | .4 | .6 | .6 | .5 | .6 | .9 | .4 | .7 |

MAP 4.6

FIRST ADMISSIONS MONTANA STATE HOSPITAL
FOUR YEAR AVERAGE 1960-1963
AGE ADJUSTED RATES PER 1,000 MONTANA POPULATION



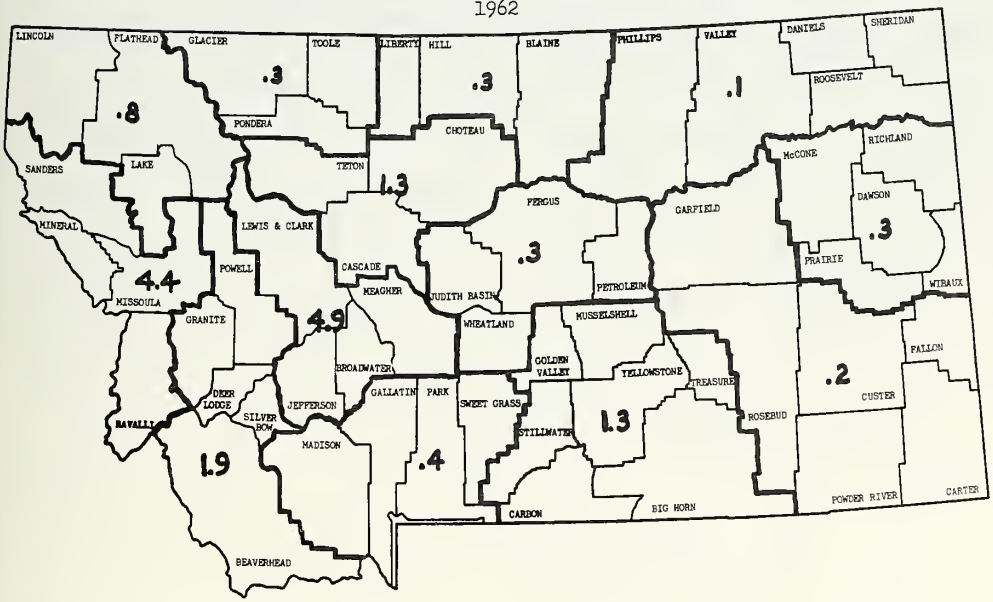

## MENTAL HYGIENE CLINICS

The age adjusted rates for patients seen at the mental hygiene clinics for the years 1962 and 1963 are presented on Maps 4.7 and 4.8. The two-year average age adjusted rate is shown on Map 4.9.

At the sites of the presently operating mental hygiene clinics, we find the highest rates. Examination of Table 4.3 reveals that the Missoula Clinic admitted nearly 43 percent of all patients received into treatment over the two-year period studied. Statistically, this would assume a higher incidence of illness in Missoula and adjacent counties than anywhere else in the state. This assumption, however, to be valid

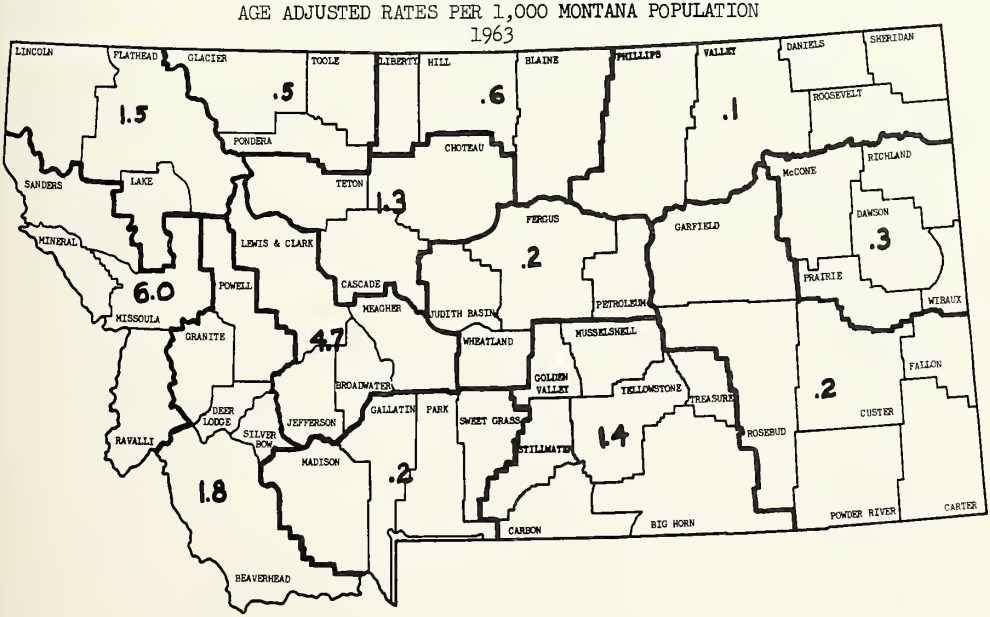
MAP 4.7

FIRST ADMISSIONS MENTAL HYGIENE CLINICS
13 ADMINISTRATIVE DISTRICTS
AGE ADJUSTED RATES PER 1,000 MONTANA POPULATION
1962




MAP 4.8

FIRST ADMISSIONS MENTAL HYGIENE CLINICS
13 ADMINISTRATIVE DISTRICTS
AGE ADJUSTED RATES PER 1,000 MONTANA POPULATION
1963



MAP 4.9

FIRST ADMISSIONS MENTAL HYGIENE CLINICS
13 ADMINISTRATIVE DISTRICTS
AGE ADJUSTED RATES PER 1,000 MONTANA POPULATION
TWO YEAR AVERAGE 1962-1963

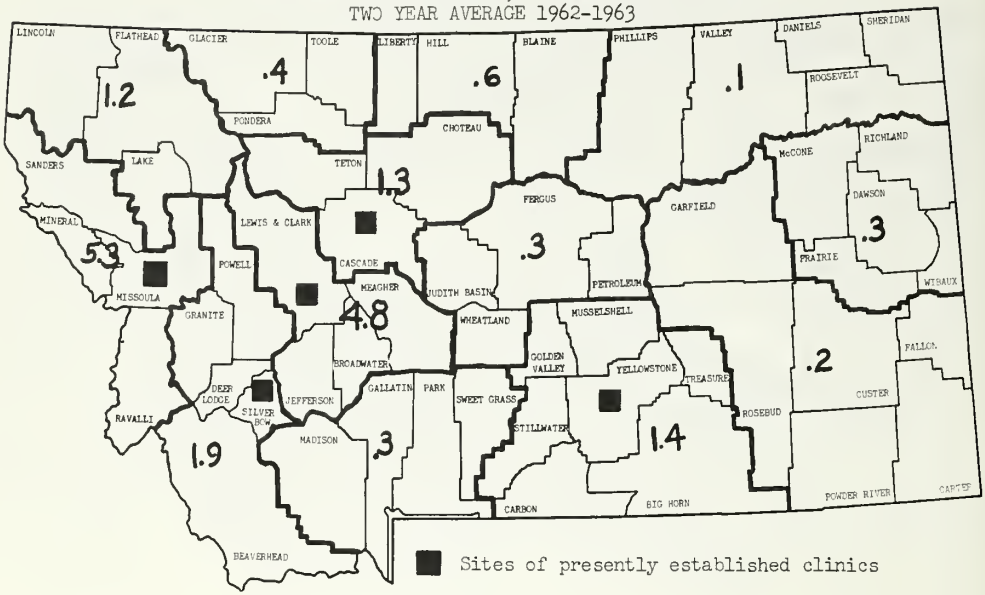



TABLE 4.3

FIRST ADMISSIONS MENTAL HYGIENE CLINICS
TOTAL FOR YEARS 1962 AND 1963
SHOWING
ADMISSION PATTERNS BY CLINIC

| CLINIC | TOTAL PATIENTS SEEN | PERCENT OF PATIENTS SEEN | PERCENT TREATED FROM: | | |
|---|---|---|---|---|---|
| | | | CO. OF LOCALE OF CLINIC | CONTIGUOUS COUNTIES | ALL OTHER COUNTIES |
| Billings | 479 | 17.0 | 77.2 | 9.0 | 13.8 |
| Butte | 371 | 13.2 | 85.2 | 14.6 | .2 |
| Great Falls | 355 | 12.6 | 73.0 | 6.8 | 20.2 |
| Helena | 403 | 14.3 | 85.9 | 6.2 | 7.9 |
| Missoula | 1209 | 42.9 | 64.9 | 28.1 | 7.0 |
| TOTALS | 2817 | | | | |

would presuppose that all contributing factors, such as staffing, were the same in all clinic settings. Since contributing factors do vary, a more exhausting examination of the clinics is needed than can be treated in the scope of this particular study. Without such a study, it is difficult to make meaningful inter-clinic comparisons.

However, some generalizations can be made which appear to have credence based on the data presently available. Table 4.3 indicates that the Missoula Clinic sees a lower percentage of patients from its county of locale than any of the other clinics. This exists in spite of the fact that it admits the largest number of patients. It is noteworthy that Missoula admissions from contiguous counties are the highest of all the clinics. Missoula is the only clinic that conducts a traveling service, and it is evident that this service increases the numbers seen in those contiguous counties into which the clinic travels. Once again it appears that when a service is made available, persons take advantage of it.

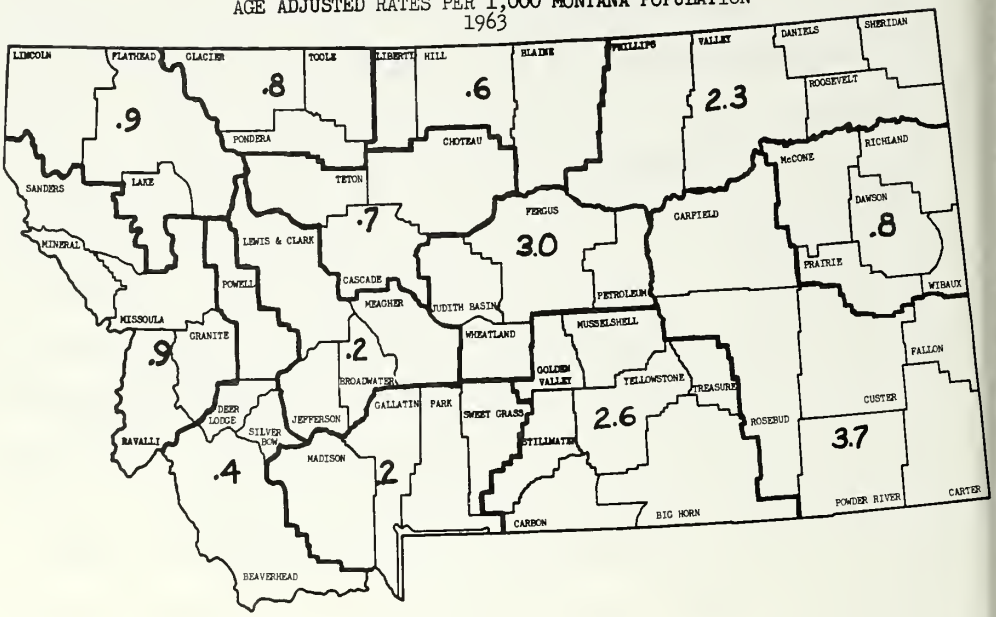
With the exception of the Missoula area it is easily discernible that the greater portion of the patients admitted into the clinics come from counties in which clinics are located. In fact, 73.4 percent of all patients seen by clinics over the two-year period studied resided in the counties having clinics. Contiguous counties accounted for 17.4 percent of all admissions, while all other counties comprised only 9.2 percent of the total patient load.

## VETERANS

Distribution of the veteran population of the state treated for psychiatric conditions in 1963 is shown on Map 4.10. Proximity again

MAP 4.10

FIRST ADMISSIONS VETERANS HOSPITALS
13 ADMINISTRATIVE DISTRICTS
AGE ADJUSTED RATES PER 1,000 MONTANA POPULATION
1963




appears to be linked to the number of admissions into veterans hospitals. The Neuropsychiatric Veterans Hospital is located at Sheridan, Wyoming, approximately 150 miles south of Billings. The proximity of this Hospital to the eastern portion of Montana seems to be closely allied with high admission rates from counties in the area. However, we do find District No. 4 presenting a high rate even though its counties and their population centers are all located a substantial distance from the facility. Contrary to the situation that exists in other facilities where populous urban centers seem to have a higher incidence of illness, the admission rate into veterans hospitals seemingly is not

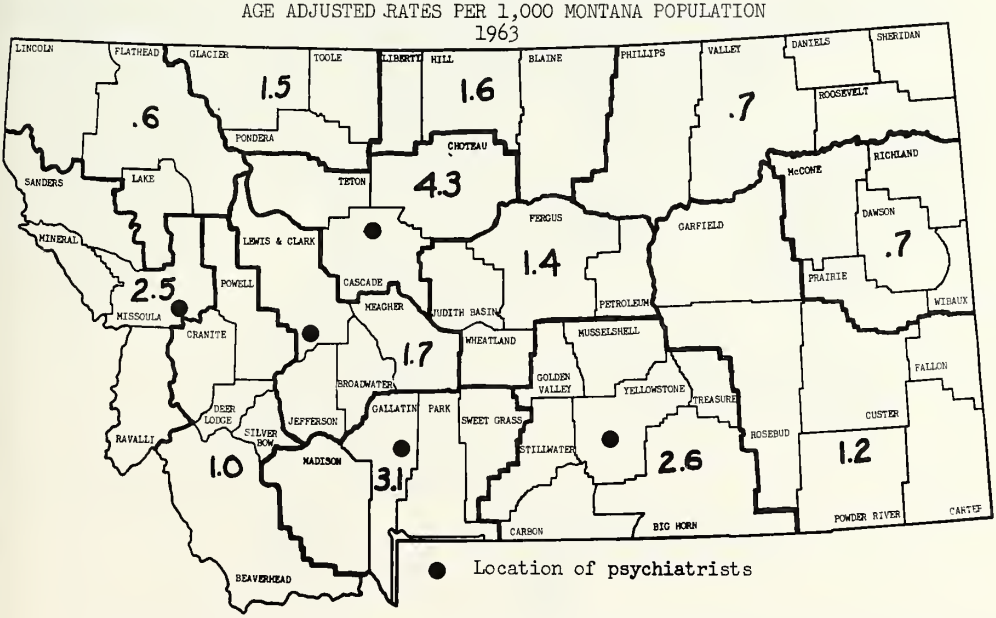
greatly affected by urbanization. Many predominantly rural districts exhibit higher rates than do the more densely populated districts.

## PRIVATE PSYCHIATRISTS

As previously requested, information was kept to a minimum. Although not reported in this study, it was noted that an additional number of patients seen by private psychiatrists in the Billings area were from border states to the east and the south of Montana. The distribution of the 1,441 cases seen by private psychiatrists are shown on Map 4.11 for the year 1963.

MAP 4.11

FIRST ADMISSIONS PRIVATE PSYCHIATRISTS
13 ADMINISTRATIVE DISTRICTS
AGE ADJUSTED RATES PER 1,000 MONTANA POPULATION
1963




A rank order correlation of .79 was found between psychiatrists in private practice by administrative districts in 1963 and total age

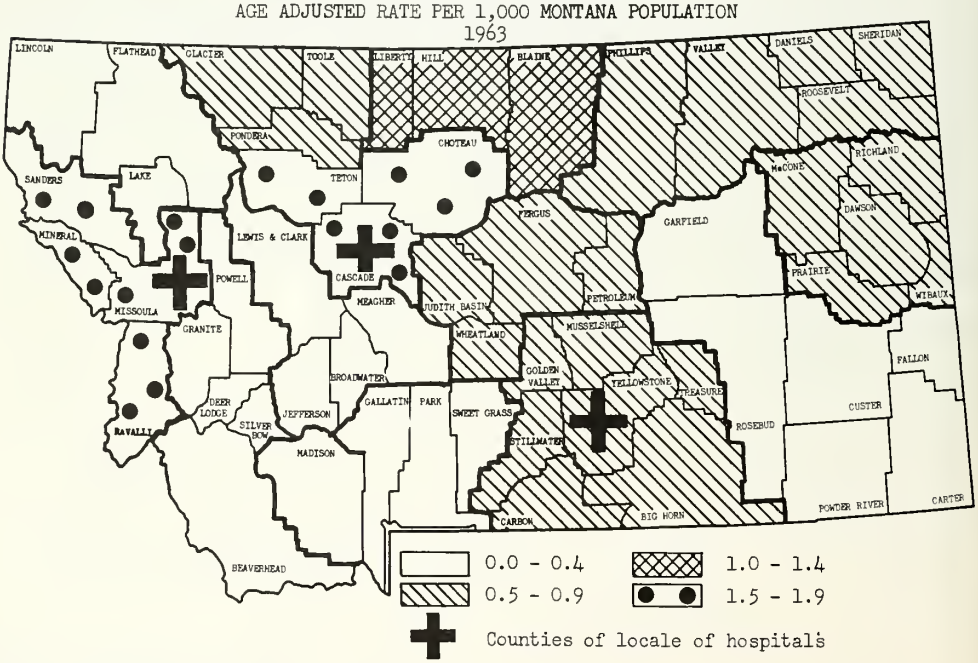
adjusted rates by the 13 administrative districts.[1]

## PRIVATE HOSPITALS

Private hospitals having psychiatric units are located at Missoula, Great Falls and Billings. Again, the requested information was limited to the previously noted criteria. Distribution of the 532 privately hospitalized patients in the three cities is shown on Map 4.12 for calendar year 1963. Each admission meets the definition of "case" used in the study.

MAP 4.12

PSYCHIATRIC FIRST ADMISSIONS TO PRIVATE HOSPITALS WITH PSYCHIATRIC UNITS
BY 13 ADMINISTRATIVE DISTRICTS
AGE ADJUSTED RATE PER 1,000 MONTANA POPULATION
1963




[1] Rank order or Spearman's rho will be used. Although some precision is lost by the use of this procedure over Pearson's r, nevertheless the nonparametric character of rho justifies its use in some parts of this study.

The shaded areas on the map indicate the county of locale of the private hospitals. Great Falls with 65.9 percent of the total beds in the state, admitted 54.3 percent of the total patients seen in private hospitals. Billings, with 19.5 percent of the beds, admitted 24.1 percent. Missoula, with 14.6 percent of the beds, admitted 21.6 percent. (See Table 4.4)

TABLE 4.4

FIRST ADMISSIONS PRIVATE HOSPITALS
SHOWING
NUMBER OF BEDS AND PATIENTS SEEN
1963

| HOSPITAL | NUMBER OF BEDS | SEX | | TOTAL | PERCENT OF PATIENT LOAD |
|---|---|---|---|---|---|
| | | MALE | FEMALE | | |
| Billings Deaconess (Billings, Montana) | 8 | 50 | 78 | 128 | 24.1 |
| Montana Deaconess (Great Falls, Montana) | 27 | 98 | 191 | 289 | 54.3 |
| St. Patricks (Missoula, Montana) | 6 | 22 | 93 | 115 | 21.6 |
| TOTALS | 41 | 170 | 362 | 532 | |

CHAPTER V

## TREATMENT FACILITIES

### MONTANA STATE HOSPITAL

Montana State Hospital, located at Warm Springs, is the only public mental hospital in the state. The site received its name from a natural hot springs bubbling up on the grounds, and was developed as a health resort for the wealthier citizens of Montana's yesteryear.

Two physicians purchased the site in 1877 to exploit the reputed medicinal powers of the hot springs. Subsequently, the territory of Montana contracted with the pair for care of the insane, and by 1911 there were approximately 800 state patients. In 1913, the state purchased Warm Springs and it became an official state-operated institution for the care of the state's mentally ill.

Montana law stipulates that persons of any age who are committed through proper procedure shall be admitted into the hospital for treatment and care. Admittance is not restricted by an individual's financial status. Cost of treatment is mainly absorbed by the state; however, state law does require that institution costs shall be assessed against the patient or responsible persons.[1] The assessed costs are based on a per diam cost computed from patient load and hospital expenditure information each July. The 1964 cost was calculated to be $5.15 per day. Although charges are computed on a per diem cost, the actual charge levied against a patient or responsible person is based on the principle of ability to

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[1] Responsible person means the patient's spouse, father, mother, children, guardian, or other court-appointed person.

pay. Chapter 199 of Montana Session Laws provides in Section 15:[1]

(1) The department shall assess monthly against each resident or responsible person the appropriate per diem charge. If the resident is an Indian who is a ward of the federal government, the per diem charge shall be assessed against the appropriate agency of the federal government. The per diem shall be computed on July 1 of each year by the director of institutions.

(2) A resident or responsible person may apply to the department for permission to pay less than the per diem charge or none of the per diem charge. On receipt of such an application, the department shall request an investigation by the county department of public welfare of the county in which the resident or responsible person is a resident. The county department of public welfare shall submit to the department, on forms furnished by the department, no later than sixty (60) days after the request, a report and recommendation on the ability of the resident or responsible person to pay all or a part of the per diem charge. Upon receipt of the report, the department shall determine, based on the financial ability of the resident or responsible person, whether the resident or responsible person shall be charged with the full amount, a lesser amount, or whether no charge against the resident or responsible person shall be made. If a resident or responsible person disagrees with the determination of the department, an appeal may be filed within thirty (30) days of the determination with the state board of institutions.

In 1964, Montana State Hospital deposited $323,316.10 to the general fund. This amount includes monies collected from other sources so was not solely obtained from State Hospital patients.

The basic daily charge for patient care reported by the National Institute of Mental Health for 1964 was $5.54.[2] This cost represents the total per capita costs. A more significant cost figure could be obtained if cost accounting were done by various hospital services, e.g., receiving hospital. It is suggested that the receiving hospital

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[1] Montana Session Laws 1965, Chapter 199, Section 15

[2] U.S., Department of Health, Education and Welfare, Public Health Service, Mental Health Statistics, Current Reports, NIMH, Series MHB-H-9, (Jan. 1965).

per capita cost would be greater than costs in a geriatric service. This information would be helpful in analyzing specific types of program operation and their relative costs.

Table 5.1 shows to what extent different therapeutic programs are used by the medical staff and treatment team at Montana State Hospital at Warm Springs.

TABLE 5.1

MONTANA STATE HOSPITAL THERAPEUTIC PROGRAM

| TYPES OF THERAPY | | FREQUENTLY | OCCASIONALLY | INFREQUENTLY OR NOT AT ALL |
|---|---|---|---|---|
| Individual Psychotherapy: | | | | |
| | by patient's private doctor | | | x |
| | by hospital-employed doctor | x | | |
| Group Psychotherapy - conducted by: | | | | |
| | psychiatrist | x | | |
| | psychologist | x | | |
| | social worker | | | x |
| | psychiatric nurse | x | | |
| | other - aides | x | | |
| Chemotherapy | | x | | |
| Electroshock | | | x | |
| Insulin coma | | | | x |
| Insulin sub-coma | | | | x |
| Planned and supervised recreational therapy | | x | | |
| Planned and supervised occupational therapy | | x | | |

Table 5.2 indicates the position titles and numbers of hospital staff persons assigned to the care of psychiatric patients. The average number of full-time employees is 555.9 for fiscal year 1964 with a ratio of average daily population to average number of full-time employees of 2.76:1.

TABLE 5.2

MONTANA STATE HOSPITAL TREATMENT PERSONNEL *

| PERSONNEL | NUMBER FULL-TIME | NUMBER PART-TIME | TOTAL FULL-TIME EQUIVA-LENCY |
|---|---|---|---|
| Psychiatrists | 5 | 0 | 5 |
| Physicians | 5 | 0 | 5 |
| Psychologists | 1 | 0 | 1 |
| Social Workers | 5 | 0 | 5 |
| Registered Nurses | 23 | 9 | 26 |
| Licensed Practical Nurses | 27 | 0 | 27 |
| Occupational Therapist Reg. | 2 | 1 | 2.50 |
| Aides, attendants | 291 | 0 | 291 |
| Others - Dentists | 0 | 1 | .50 |

* Information obtained from Montana State Hospital. Numbers cited as of February 1, 1965.

Table 5.3 shows patient movement statistics for fiscal years 1955 to 1964.

TABLE 5.3

MONTANA STATE HOSPITAL
PATIENT MOVEMENT
1955 - 1964

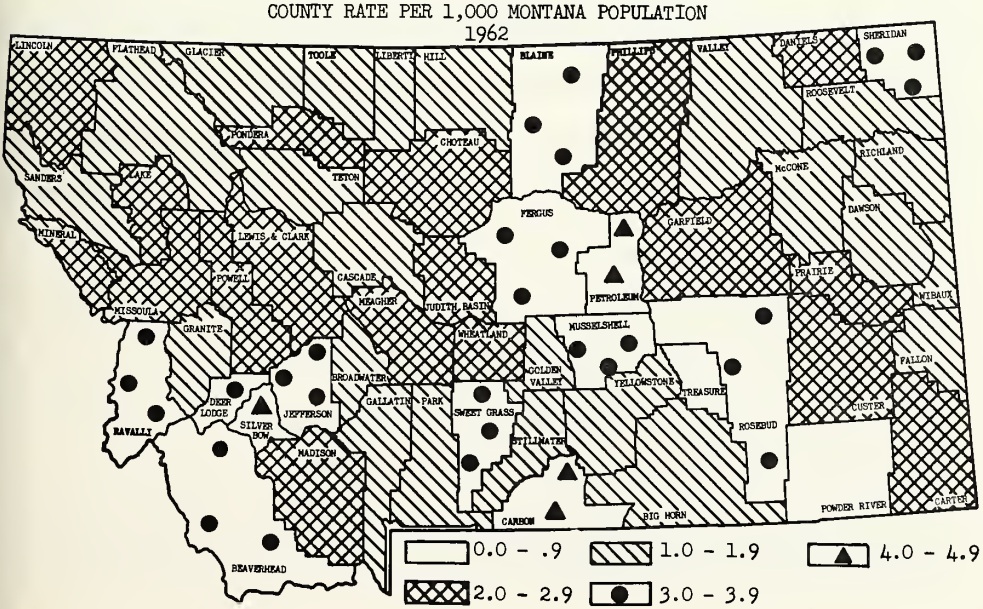
| FISCAL YEAR | 1955 | 1956 | 1957 | 1958 | 1959 | 1960 | 1961 | 1962 | 1963 | 1964 |
|---|---|---|---|---|---|---|---|---|---|---|
| TOTAL ADMISSIONS | 873 | 916 | 919 | 1,019 | 1,076 | 1,175 | 1,449 | 1,888 | 1,419 | 1,566 |
| SEPARATIONS: | | | | | | | | | | |
| DISCHARGES | 566 | 674 | 1,020 | 861 | 849 | 938 | 1,466 | 1,053 | 1,219 | 1,381 |
| DEATHS | 188 | 214 | 194 | 220 | 217 | 188 | 185 | 200 | 166 | 214 |
| TOTAL | 754 | 888 | 1,214 | 1,081 | 1,066 | 1,126 | 1,651 | 1,255 | 1,385 | 1,595 |
| ON BOOKS: | | | | | | | | | | |
| END OF YEAR | 2,418 | 2,446 | 2,151 | 2,089 | 2,099 | 2,148 | 1,946 | 1,897 | 1,931 | 1,902 |
| IN HOSPITAL | 1,919 | 1,860 | 1,762 | 1,730 | 1,673 | 1,662 | 1,711 | 1,624 | 1,587 | 1,535 |
| ON VISIT | 499 | 586 | 389 | 359 | 426 | 486 | 228 | 269 | 331 | 360 |
| AVERAGE DAILY POPULATION | 1,956 | 1,905 | 1,818 | 1,750 | 1,701 | 1,665 | 1,691 | 1,656 | 1,600 | 1,541 |
| NO. PATIENTS TREATED | 2,831 | 2,835 | 2,779 | 2,781 | 2,806 | 2,848 | 3,111 | 2,907 | 3,043 | 3,153 |

**NOTE:** Information for this Table was adapted from the Montana State Hospital Report, 52 Years of Progress, 1912-1964.

Maps 5.1 and 5.2 show the resident population at Montana State Hospital as reported on July 1, 1962 and July 1, 1964. A rate per thousand county population was calculated and reported on the maps. Rates are more significant for comparison purposes and their utilization here makes it possible to compare the relative position of a county under study to any other county regardless of population density. We note a high resident population in most counties that are contiguous to Deer Lodge County where the Hospital is located. However, it is noted that there are some significantly high rates in counties that are of considerable distance away. It is interesting that many of the northern and eastern plains counties show relatively high rates in both reporting periods. This would seem to indicate that the Hospital's custodial treatment or perhaps more properly the instances of long patient tenure are fairly well distributed throughout the state.

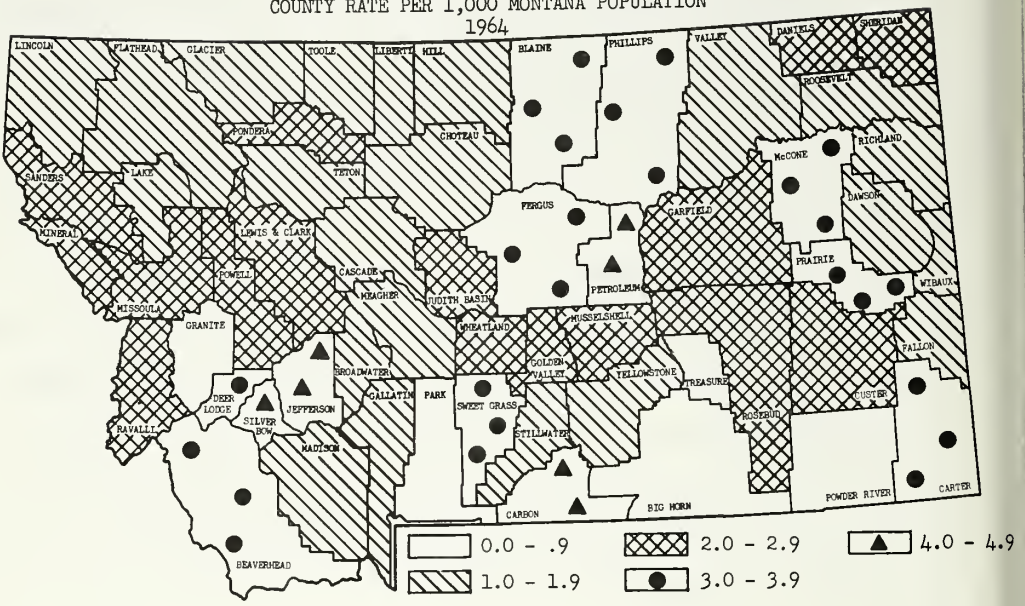
MAP 5.1

RESIDENT PATIENTS AT MONTANA STATE HOSPITAL
COUNTY RATE PER 1,000 MONTANA POPULATION
1962



MAP 5.2

RESIDENT PATIENTS AT MONTANA STATE HOSPITAL
COUNTY RATE PER 1,000 MONTANA POPULATION
1964




Of the total patients admitted to Montana State Hospital in fiscal 1963, approximately 58.8 percent were first admissions. In calendar year 1964, a controlled study was done of first admissions and readmissions. Of the total patients admitted to Montana State Hospital in calendar year 1964, 56.0 percent were first admissions.

The average length of stay per discharged patient was not available. However, with the addition of an IBM accounting machine to Montana State Hospital, this type of statistical information will be readily tabulated once a system of card punching is established.

Montana is not affiliated with a medical school and has no residency program. There is a possibility of the State Hospital arranging internships

in professional mental health fields. The major difficulty is money and the acquisition of professional staff in order to implement an internship program. Student nursing programs in Montana require a college quarter unit in psychiatric nursing. The training of student nurses at Montana State Hospital is a joint operation with Montana State Hospital furnishing clinical facilities and Montana State College furnishing faculty. Training of attendants is an important program. An in-service training program is conducted weekly for approximately 200 regularly employed attendants. All professional departments conduct in-service training where personnel are instructed in the latest techniques of psychiatric treatment. This intensive in-service training program has been effectual in upgrading staff and services offered.

Over the years, Montana State Hospital has been licensed by the State Board of Health for varying numbers of beds. On the September 14, 1964 list of licensed hospitals in the state, Montana State Hospital is not shown.[1] The Board of Public Institutions on October 5, 1964 requested that "the Board of Health establish definite rated capacity figures for the State Hospital at Warm Springs". A task force for this purpose was organized and a survey conducted on October 27 and 28, 1964.

On the basis of 70 square feet per bed, the survey established a rated capacity of 1,467 beds.[2] On the basis of listing beds which conform or do not conform to regulations, a different picture evolves.

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[1] List published by the State Board of Health, Division of Environmental Sanitation, Helena, Montana.

[2] American Psychiatric Association, Standards for Hospitals and Clinics (Washington, D.C.: American Psychiatric Association, 1956), p. 42.

Those beds which conformed to fire and structural regulations and to space allocation standards set by the American Psychiatric Association numbered 456. This leaves 1,011 or 68.9 percent of the total beds at the State Hospital that cannot meet requirements.

## MENTAL HYGIENE CLINICS

Montana's mental hygiene clinics function as outpatient facilities.[1] As such, they play an important role in prevention of mental illness as well as assisting the individual with mental or emotional problems to maintain himself at a level of social functioning in the community. The crucial role exercised by the clinic in the life of the person who requires its services is well recognized by many communities.

The increase in the number of psychiatric clinics since 1962 is documentary evidence of the new emphasis being placed on the development of these services. In 1962, clinics numbered 500 in these United States; in 1964, this number had grown to 1800.[2]

In recent years, the concept of "community psychiatry" has gained credence as the modus operandi having the most credibility. This concept has been given greater impetus with the addition of the concept of the comprehensive community mental health center. The role of the clinic takes on new vitality with the addition of the community center into the

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[1] A psychiatric clinic is defined as an outpatient mental health service unit with a psychiatrist in attendance at regularly scheduled hours who takes the medical responsibility for all clinic patients.

[2] National Institute of Mental Health, Biometrics Branch, Outpatient Studies Section, "Recent Development in Outpatient Mental Health Statistics Program". (October 1963).

treatment complex. The reciprocal flow of patients and records between the intensive inpatient treatment of the center, and the prior and follow-up treatment of the clinic would be invaluable in providing a continuum of services to the individual.

There are five state-operated psychiatric clinics presently offering full or partial services. These are located at Billings, Butte, Great Falls, Helena, and Missoula. See Map 3.1 for location.[1] An initial staffing pattern for the clinics should include in its complement of personnel: one psychiatrist, one psychologist, and two psychiatric social workers. It is emphasized that the staffing patterns as suggested above and as shown in the following table are not regidly set, but on the contrary should be as flexible as budgetary and administrative commitments will allow it to be - thus permitting staffing to meet the demands of each clinic's program. Table 5.4 contrasts the above recommended pattern of clinic staffing with the situation as it actually exists. In all cases, budgetary restriction accounts for staff vacancies at this time.

TABLE 5.4

RECOMMENDED AND EXISTING STAFFING PATTERNS
OF STATE MENTAL HYGIENE CLINICS
JANUARY 1965

| RECOMMENDED STAFFING | | EXISTING STAFFING FULL AND PART-TIME | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | BILLINGS | | BUTTE | | GREAT FALLS | | HELENA | | MISSOULA | |
| POSITION | NO. | FULL | PART | FULL | PART | FULL | PART | FULL | PART | FULL | PART |
| Psychiatrist | 1 | 1 | - | - | 1 | - | 1 | 1 | - | 1 | - |
| Clinical Psychologist | 1 | 1 | - | - | 2 | 1 | - | 1 | - | 1 | - |
| Psychiatric Social Worker | 2 | 1 | - | - | - | 2 | - | - | - | 2 | - |
| Clerical | as needed | 1 | - | 1 | - | 1 | 1 | 1 | - | 1 | 1 |
| TOTALS | | 4 | - | 1 | 3 | 4 | 2 | 3 | - | 5 | 1 |

[1] Supra, p. 39.

Table 5.5 shows a breakdown of patient movement for the clinics during the calendar year 1964. Out of the total number admitted during the year, it is of interest that over 80 percent were new admissions.

Total admissions to the clinics in 1964 were 1,804 cases. New admissions accounted for 1,446 of these, and readmissions, 358. There were 970 patients carried over from the previous year's case load. Of the 1964 total number (2,774) of patients - either first admitted or carried over from 1963 - 57.3 percent were terminated during the year, and 42.7 percent were carried over into the 1965 calendar year.

TABLE 5.5

MOVEMENT OF PATIENTS
STATE MENTAL HYGIENE CLINICS
1964

| CATEGORY | PATIENTS UNDER 18 YEARS | | PATIENTS 18 TO 65 YEARS | | PATIENTS 65 YEARS AND OVER | | TOTAL | PERCENT IN CATEGORY |
|---|---|---|---|---|---|---|---|---|
| | NO. | % | NO. | % | NO. | % | NO. | |
| Number of patients carried over from previous year | 497 | 51.2 | 462 | 47.6 | 11 | 1.2 | 970 | |
| Number of new admissions during year | 768 | 53.1 | 673 | 46.5 | 5 | .4 | 1446 | 80.2 |
| Number of readmissions during year, patients last terminated in a prior calendar year | 136 | 49.6 | 138 | 50.4 | - | - | 274 | 15.2 |
| Number of readmissions during year, patients last terminated during this calendar year | 37 | 44.0 | 47 | 56.0 | - | - | 84 | 4.6 |
| Number of patients terminated during year | 794 | 50.0 | 785 | 49.4 | 10 | .6 | 1589 | 57.3 |
| Number of patients carried over to next year | 644 | 54.3 | 535 | 45.2 | 6 | .5 | 1185 | 42.7 |

The staff of an established clinic give considerable time during and after hours to public service to various segments of the community in which they live. Such services were surveyed for 1964, and it is well worth documenting the service given. Table 5.6 presents an itemized account of the types of services rendered and the number of hours supplied in each.

TABLE 5.6

COMMUNITY SERVICES
STATE MENTAL HYGIENE CLINICS
1964

| TYPE OF SERVICE | NUMBER OF PROFESSIONAL HOURS | |
|---|---|---|
| | DURING CLINIC HOURS | AFTER CLINIC HOURS |
| A. Information and Education Services for General Public | | |
| 1. Single presentation (lectures, talks) | 234.0 | 109.5 |
| 2. Group study - intensive limited period (workshop, institute) | 32.0 | 45.5 |
| 3. Group study - periodic sessions, over longer period | - | 3.0 |
| 4. Mass media (radio, television, newspapers, pamphlets) | 2.0 | 1.5 |
| 5. Visitors | 51.0 | 16.0 |
| B. In-Service Training for Professional Groups | | |
| 1. School personnel | 4.0 | - |
| 2. Court, probation officers, police | 21.0 | - |
| 3. Social and welfare personnel | 10.0 | - |
| 4. Health personnel (physicians, nurses, etc.) | 65.0 | - |
| 5. Others (clergy, etc.) | 47.0 | 7.5 |
| C. Consultations and Conferences with Other Agencies | | |
| 1. Schools | 260.0 | 33.0 |
| 2. Courts, probation officers, police | 111.0 | 6.0 |
| 3. Social and welfare agencies | 162.5 | 6.0 |
| 4. Health agencies (including private physicians) | 301.0 | 14.5 |
| 5. Other agencies | 118.0 | 3.0 |
| D. Participation in Community Planning and Coordination | 695.0 | 258.5 |
| E. Total Number of Hours for Community Services | 2113.5 | 504.0 |

The professional man-hours indicated reflect the civic pride and interest that the clinic personnel have in their communities. For those hours which the clinic staff spends in community education, participation in community planning, etc., after the regular clinic schedule, they are allowed compensatory time and travel expense. However, often staffs donate time and travel above what is expected of them.

It is important when we consider the treatment phase of a clinic operation that cognizance be given to the number of interviews with or about a patient, so that professional time involvement might be better understood. Tables 5.7 and 5.8 indicate by sex and age the number of patients and number of interviews in the cited categories. To provide a more accurate breakdown, a two-year average is presented. From the data presented, determinations can be made with respect to the age groups that are receiving the larger number of interviews. Generally, it can be determined that the younger patient receives the greater proportion of the time of the treatment personnel.

A report submitted by the Joint Commission on Mental Illness and Health, Action for Mental Health, states that "less than a fourth of the counties in the nation have mental health clinics".[1] This statistic was considered by the Commission to point out an "obvious extreme" need for more mental health clinics. In view of the fact that less than nine percent of Montana's counties have mental health clinics, it could be assumed that an even greater need exists in Montana to establish more services.

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[1]Joint Commission on Mental Illness and Health, Action for Mental Health, Final Report (New York: Basic Books, Inc., 1961), p. 120.

TABLE 5.7

AVERAGE NUMBER OF MALE PATIENT INTERIVEWS
BY AGE AND SEX FOR
1962-1963

| AGE | WITH PATIENT | | PARENTS OR SUBSTITUTES | | SPOUSE | | OTHER SIGNIFICANT PERSONS | | TOTAL INTERVIEWS | |
|---|---|---|---|---|---|---|---|---|---|---|
| | NO.PTS. | AVG.INT. | NO.PTS. | AVG.INT. | NO.PTS. | AVG.INT. | NO.PTS. | AVG.INT. | NO.PTS. | AVG.INT. |
| 0 - 4 | 8.0 | 2.8 | 7.0 | 4.9 | 0 | 0 | 2.5 | 2.8 | 8.0 | 7.9 |
| 5 - 9 | 19.5 | 10.2 | 18.5 | 18.0 | 0 | 0 | 7.0 | 6.1 | 20.5 | 28.0 |
| 10 - 14 | 20.0 | 11.9 | 17.5 | 19.2 | 0 | 0 | 10.0 | 3.9 | 20.5 | 29.9 |
| 15 - 19 | 12.5 | 8.2 | 10.5 | 9.4 | 0 | 0 | 5.0 | 5.0 | 13.0 | 17.5 |
| 20 - 24 | 9.0 | 12.4 | 6.5 | 2.9 | 1.0 | 8.0 | 3.5 | 2.4 | 9.5 | 15.5 |
| 25 - 29 | 9.0 | 6.4 | 1.5 | 1.7 | 4.0 | 2.8 | 1.5 | 1.7 | 9.5 | 7.8 |
| 30 - 34 | 8.0 | 4.9 | 1.5 | 2.0 | 3.0 | 4.7 | 0 | 0 | 8.0 | 7.0 |
| 35 - 39 | 7.0 | 7.1 | 1.5 | 1.3 | 3.0 | 4.3 | 1.5 | 9.0 | 7.0 | 11.2 |
| 40 - 44 | 5.5 | 3.3 | 1.0 | 1.0 | 1.5 | 4.3 | .5 | 1.0 | 5.5 | 4.7 |
| 45 - 49 | 5.5 | 3.6 | .5 | 1.0 | 2.0 | 2.3 | .5 | 1.0 | 5.5 | 4.6 |
| 50 - 54 | 6.0 | 3.1 | .5 | 2.0 | 3.5 | 2.3 | 2.0 | 2.5 | 6.0 | 5.4 |
| 55 - 59 | 3.5 | 4.4 | .5 | 12.0 | .5 | 2.0 | 0 | 0 | 3.5 | 6.4 |
| 60 - 64 | 3.0 | 1.5 | .5 | 2.0 | .5 | 2.0 | 1.0 | 1.0 | 3.0 | 2.0 |
| 65 - 69 | 1.0 | 2.0 | 0 | 0 | 0 | 0 | 0 | 0 | .5 | 2.0 |
| 70 - 74 | 1.5 | 1.7 | 0 | 0 | .5 | 1.0 | .5 | 1.0 | 1.5 | 2.3 |
| 75 - 79 | 1.0 | 2.5 | .5 | 3.0 | 0 | 0 | 0 | 0 | 1.0 | 4.0 |
| 80 - 84 | 1.0 | 2.0 | 0 | 0 | 0 | 0 | 0 | 0 | .5 | 2.0 |
| 85 + | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| TOTALS | 119.0 | 7.6 | 68.0 | 12.4 | 19.5 | 3.5 | 35.5 | 4.1 | 123.0 | 15.9 |

TABLE 5.8

AVERAGE NUMBER OF FEMALE PATIENT INTERVIEWS
BY AGE AND SEX FOR
1962-1963

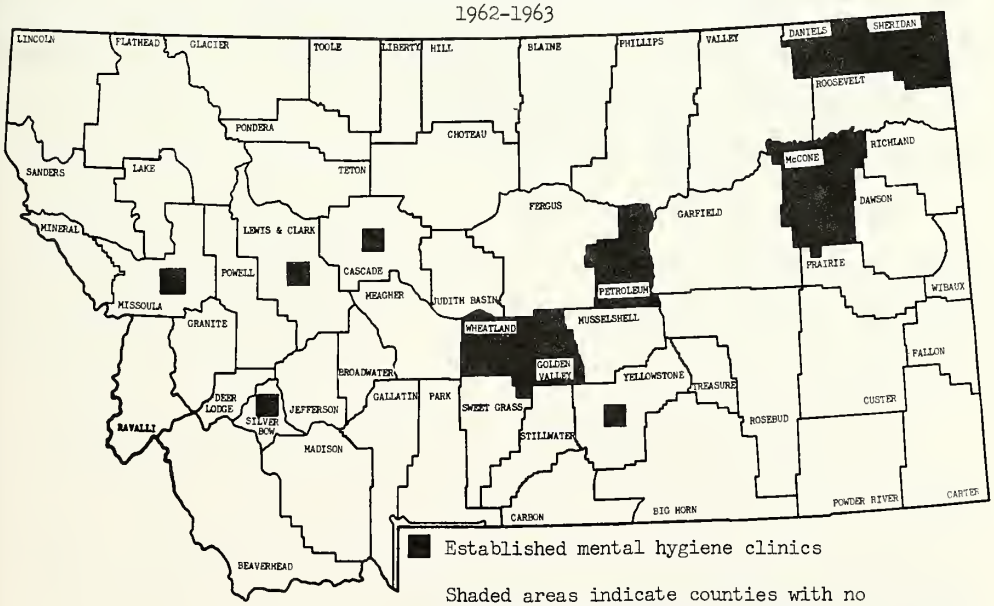
| AGE | WITH PATIENT | | PARENTS OR SUBSTITUTES | | SPOUSE | | OTHER SIGNIFICANT PERSONS | | TOTAL INTERVIEWS | |
|---|---|---|---|---|---|---|---|---|---|---|
| | NO.PTS. | AVG.INT. | NO.PTS. | AVG.INT. | NO.PTS. | AVG.INT. | NO.PTS. | AVG.INT. | NO.PTS. | AVG.INT. |
| 0 - 4 | 6.0 | 2.8 | 6.5 | 4.5 | 0 | 0 | 2.0 | 1.5 | 7.5 | 6.6 |
| 5 - 9 | 19.0 | 4.3 | 19.0 | 7.6 | 0 | 0 | 5.5 | 4.9 | 19.5 | 12.6 |
| 10 - 14 | 16.5 | 7.7 | 17.0 | 9.1 | 0 | 0 | 4.5 | 8.7 | 17.5 | 18.3 |
| 15 - 19 | 12.5 | 14.4 | 10.5 | 9.5 | 1.5 | 1.7 | 3.0 | 8.8 | 13.0 | 23.7 |
| 20 - 24 | 11.0 | 11.8 | 4.5 | 1.8 | 4.0 | 3.0 | 3.5 | 3.1 | 12.0 | 13.4 |
| 25 - 29 | 7.5 | 13.4 | .5 | 18.0 | 2.5 | 6.0 | 1.5 | 1.3 | 7.5 | 16.9 |
| 30 - 34 | 9.0 | 10.3 | 2.0 | 1.3 | 4.0 | 4.0 | 2.5 | 1.2 | 9.0 | 12.7 |
| 35 - 39 | 8.0 | 6.9 | 1.5 | 1.0 | 3.0 | 3.0 | .5 | 1.0 | 6.0 | 8.3 |
| 40 - 44 | 7.5 | 7.1 | 1.5 | 1.7 | 2.5 | 3.4 | 3.0 | 2.8 | 7.5 | 7.7 |
| 45 - 49 | 6.0 | 7.0 | 1.0 | 1.5 | 2.5 | 3.8 | 1.0 | 1.5 | 6.5 | 8.4 |
| 50 - 54 | 5.0 | 4.0 | .5 | 1.0 | 1.0 | 2.5 | 1.0 | 2.0 | 5.0 | 5.0 |
| 55 - 59 | 4.0 | 3.1 | 0 | 0 | 1.5 | 1.0 | 2.0 | 2.5 | 4.0 | 4.8 |
| 60 - 64 | 1.5 | 1.3 | 0 | 0 | 0 | 0 | 1.0 | 1.0 | 2.0 | 1.5 |
| 65 - 69 | 1.0 | 4.0 | 0 | 0 | 0 | 0 | 0 | 0 | 1.0 | 4.0 |
| 70 - 74 | .5 | 2.0 | 0 | 0 | 0 | 0 | .5 | 2.0 | 1.0 | 2.0 |
| 75 - 79 | .5 | 1.0 | 0 | 0 | 0 | 0 | .5 | 1.0 | 1.0 | 1.0 |
| 80 - 84 | .5 | 1.0 | .5 | 1.0 | 0 | 0 | .5 | 2.0 | .5 | 4.0 |
| 85 + | 0 | 0 | 0 | 0 | 0 | 0 | .5 | 1.0 | .5 | 1.0 |
| TOTALS | 116.0 | 7.9 | 65.0 | 7.0 | 22.5 | 3.4 | 33.0 | 3.9 | 123.0 | 12.8 |

The fees collected from patients utilizing clinic assistance are small in comparison with the amount of service rendered. During fiscal 1964, only $10,396.00 was turned back into the state's general fund. Fees collected are based on a sliding scale according to the individual's ability to pay.

To obtain clinic help, persons from many counties are required to travel substantial distances. However, from the clinic study done for the years 1962 and 1963, it is noted that people are willing to travel for service. As indicated by Map 5.3, only six counties in the state did not exhibit one or more cases during the 1962-1963 period of study.

MAP 5.3

LOCATION OF ESTABLISHED MENTAL HYGIENE CLINICS
AND COUNTIES SHOWING NO ADMISSIONS INTO CLINICS
1962-1963



## VETERANS ADMINISTRATION HOSPITALS

The Veterans Administration Hospital located at Sheridan, Wyoming has the primary responsibility for service to Montana's veterans who need neuropsychiatric hospitalization. However, veterans hospitals located at Fort Mead, South Dakota and American Lake, Washington also report first admissions of veterans from Montana.

Before a veteran is eligible to receive hospitalization benefits from the Veterans Administration, he must have had "active service in the military, naval, or air service of the United States and discharge or release from such service under conditions other than dishonorable".[1] General admission priorities give preference to veterans with service connected disabilities. The veteran with a non-service connected disability is also eligible to receive hospitalization but only if the following conditions are met: "(1) hospitalization is deemed necessary; (2) they state under oath they are financially unable to defray the cost of the necessary charges elsewhere; and (3) if beds are available".[2]

Outpatient medical treatment may be furnished the neuropsychiatric service connected veteran in his home community provided that the Veterans Administration authorizes such treatment and psychiatric services are available.

The Sheridan, Wyoming Veterans Administration Hospital estimates Montana residents comprise as much as 35 percent of the Hospital's inpatient load at any given time. In 1963, the Sheridan Hospital reported

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[1] Federal Benefits for Veterans and Dependents, V.A. Fact Sheet IS-1, February 1963, p. 6. This pamphlet and a call to the nearest V.A. or State Veteran Welfare Office will explain in more detail eligibility requirements.

[2] Ibid, p. 6.

106 first admissions. Fort Mead Hospital reported six, and American Lake Hospital reported four first admissions. Map 4.10 in the Chapter on Spatial Distribution reports all veteran first admissions by age adjusted rates by 13 administrative districts.[1] Of the above number of first admissions in 1963, 91.4 percent were admitted to the Sheridan Veterans Administration Hospital.

## PRIVATE PSYCHIATRISTS

Private facilities in Montana for the diagnosis and treatment of the emotionally ill are located in the larger urban centers. Psychiatrists in private practice are distributed in the state as seen in Table 5.9 and on Map 5.4.

TABLE 5.9

MONTANA PSYCHIATRISTS IN EITHER PUBLIC OR PRIVATE PRACTICE
JANUARY 1965

| COUNTY | CITY | TOTAL NUMBER OF PSYCHIATRISTS | PRACTICE | |
|---|---|---|---|---|
| | | | PRIVATE | PUBLIC |
| Cascade | Great Falls | 4 | 3½ | ½ |
| Custer | Miles City | 1 | ½ | ½ |
| Deer Lodge | Warm Springs | 5 | - | 5 |
| Flathead | Kalispell | 1 | 1 | - |
| Gallatin | Bozeman | 1 | ½ | ½ |
| Lewis and Clark | Helena | 1 | - | 1 * |
| Missoula | Missoula | 2 | 1 | 1 |
| Yellowstone | Billings | 6 | 5 | 1 |
| TOTALS | | 21 | 11½ | 9½ |

* Some private practice after clinic hours

Upon examining Map 5.4, we find that seven counties in the state have one or more psychiatrists doing some private practice within county

[1] Supra, p. 74.

boundaries. These seven counties collectively represent 40.8 percent of the population of Montana.

The map also indicates that two psychiatrists have set up private practice in the state since 1964 in Flathead and Custer Counties.

MAP 5.4

LOCATION OF MONTANA PSYCHIATRISTS IN PRIVATE PRACTICE
JANUARY 1965

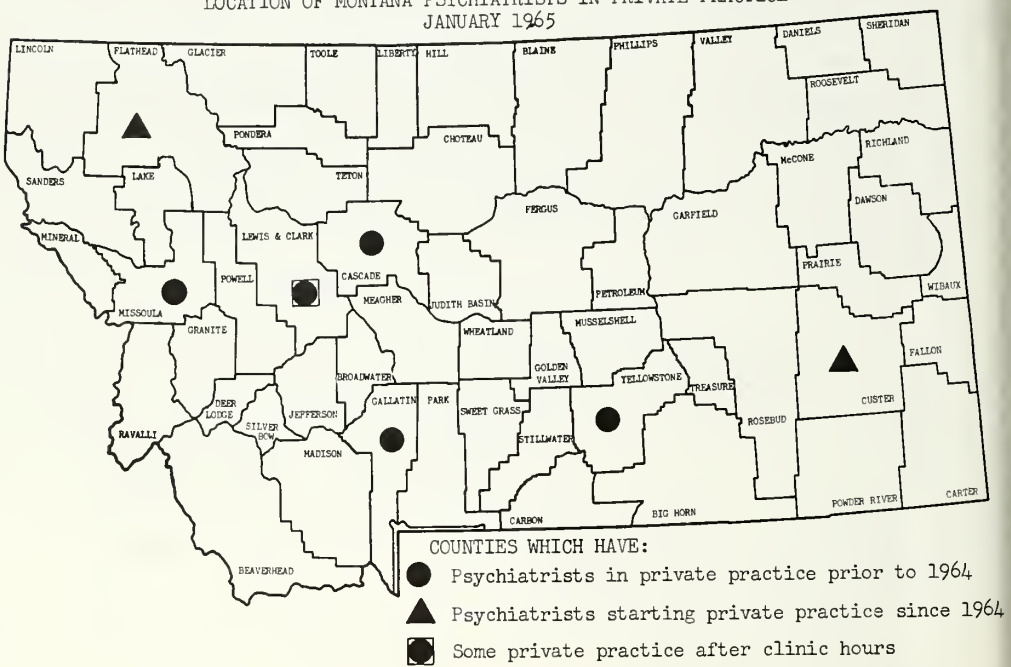



Table 5.9 indicates the location and number of public and private psychiatrists in the state. From this Table we learn that the amount of psychiatrists' time being devoted to private and public service is $11\frac{1}{2}$ and $4\frac{1}{2}$ units respectively. One psychiatrist in Helena, employed by the state, is doing some private practice after state clinic hours.

## NON-PSYCHIATRIC PHYSICIANS

A questionnaire was sent to all physicians known to be engaged in private practice in Montana.[1] Physicians employed by state government agencies were excluded from the study, as were private psychiatrists. Likewise, practicing physicians under military auspices were not included. A breakdown of the physicians in Montana by proposed mental hygiene clinic districts is given in Table 5.10.

TABLE 5.10

MONTANA PHYSICIANS IN PRIVATE PRACTICE
BY MENTAL HYGIENE DISTRICTS
1964

| MENTAL HYGIENE DISTRICT | NO. OF PHYSICIANS IN DISTRICT | PHYS. EXCLUDED TOTAL | NO. OF PHYSICIANS IN DISTRICT | PERCENT DISTRICT HAS OF TOTAL STATE | DISTRICT POPULATION 1 | NO. OF PHYSICIANS PER 1,000 MONTANA POPULATION |
|---|---|---|---|---|---|---|
| Billings | 138 | 15 | 123 | 19.5 | 120,800 | 1.0 |
| Bozeman | 54 | 4 | 50 | 7.9 | 45,200 | 1.1 |
| Butte | 79 | 18 | 61 | 9.7 | 73,400 | .8 |
| Glasgow | 54 | 26 | 28 | 4.4 | 59,300 | .5 |
| Great Falls | 162 | 32 | 130 | 20.6 | 164,700 | .8 |
| Helena | 62 | 14 | 48 | 7.6 | 39,600 | 1.2 |
| Kalispell | 56 | 3 | 53 | 8.4 | 61,100 | .9 |
| Miles City | 45 | 6 | 39 | 6.2 | 63,400 | .6 |
| Missoula | 109 | 10 | 99 | 15.7 | 79,500 | 1.2 |
| TOTALS | 759 | 128 | 631 | | 707,000 | .9 |

1 Montana State Board of Health, Division of Records and Statistics, Population Estimates Montana, July 1, 1963.

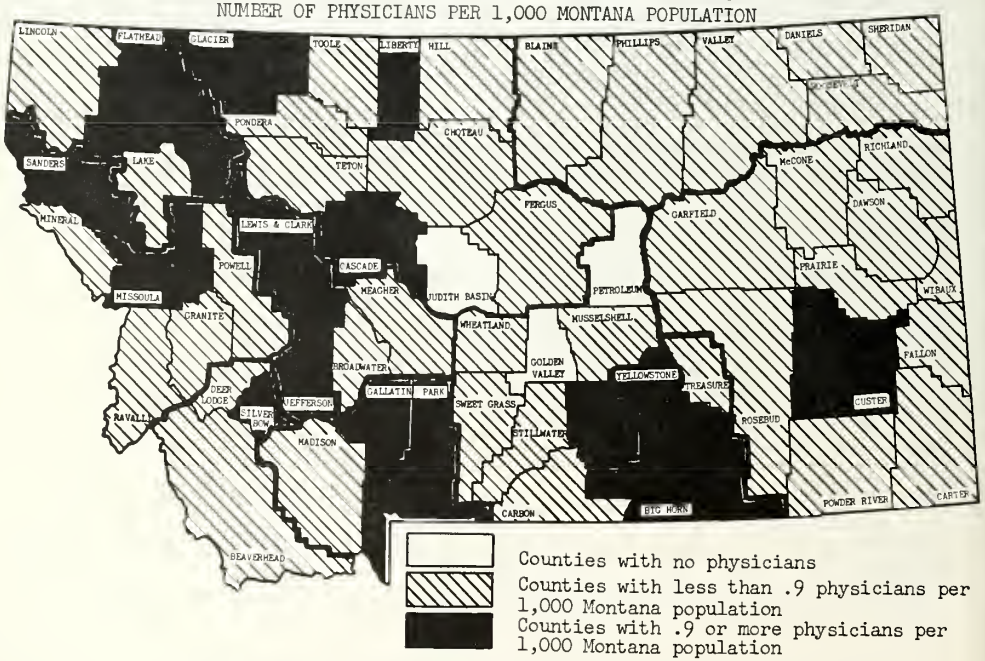
[1] Refer to Montana, State Board of Health, Physician Listing, Revised to July 20, 1964.

The number of physicians per 1,000 Montana population was computed by using the figures as represented under the "Number of Physicians in Study" column. These figures represent a substantially more veracious presentation of physicians actually engaged in private practice than do those in the column under "Number of Physicians in District" because of certain exclusions made that are described above.

Map 5.5 shows a breakdown by county and mental hygiene districts of the number of physicians in private practice per 1,000 Montana population.

MAP 5.5

MONTANA PRIVATE PHYSICIANS
BY RESIDENT COUNTY AND MENTAL HYGIENE DISTRICT
NUMBER OF PHYSICIANS PER 1,000 MONTANA POPULATION




It is evident, when we study those counties which are at state average or above, that our urban sections of the state are much more substantially serviced. Even in the 38 counties that are designated

below state average, we find the majority of physicians located within the larger urban centers of the counties. Three Montana counties as yet have no resident physicians practicing within their boundaries.

Availability of help seems to be a decisive factor in the number of people who seek it. This likewise appears to be the situation nationally as we observe from this statement from Action for Mental Health: "The authors believe that a critical factor that led some to seek expert help was the availability of help and their awareness of it".[1]

Some contend that the first line of defense against mental illness is the physicians in private practice. The statistics ascertained from the questionnaire sent by the project to the physicians would certainly point up the factuality that their role is a prominent one in Montana. It must be conceded that the results of the questionnaire can only be considered indicative. However, national statistics substantiate the study indicating that physicians rank second only to clergymen as those to whom people go for help.[2]

In thus assessing the over-all program of services to those who require assistance, we can conclude from further examination of Map 5.5 that Montana's rural population is not receiving the type of assistance in their community commensurate with that being rendered to the urban resident.

Table 5.11 is a breakdown of the information received from Montana

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[1]Joint Commission on Mental Illness and Health, Action for Mental Health, Final Report (New York: Basic Books, Inc., 1961), p. 105.

[2]Ibid, p. 103.

TABLE 5.11

1963 REPORT OF MONTANA PHYSICIANS
CONCERNING PATIENTS REQUIRING PSYCHIATRIC TREATMENT
BUT NOT TREATED BECAUSE FACILITIES OR SERVICES
WERE NOT AVAILABLE

A. How many of your patients whom you felt required treatment for psychiatric illness were not treated because facilities or services were not available to them? (B-G)
   B. Clinic service not available?
   C. No special class for the emotionally disturbed in either public or parochial school?
   D. No psychiatric unit in county hospital?
   E. Private psychiatric treatment not readily available?
   F. Private neurological treatment not readily available?
   G. Patient or relative resistive to referral?

| CLINIC DISTRICT | TOTAL NO. NOT TREATED DUE TO LACK OF FAC. | PHYSICIANS REPORTING | B | | C | | D | | E | | F | | G | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | NUMBER | % | NUMBER | % | NUMBER | % | NUMBER | % | NUMBER | % | NUMBER | % |
| Billings | 127 | 52 | 10 | 19.2 | 9 | 17.3 | 8 | 15.4 | 7 | 13.5 | 1 | 1.9 | 17 | 32.7 |
| Bozeman | 19 | 26 | 5 | 19.2 | 5 | 19.2 | 4 | 15.4 | 4 | 15.4 | 1 | 3.9 | 7 | 26.9 |
| Butte | 205 | 54 | 11 | 20.4 | 5 | 9.3 | 8 | 14.8 | 16 | 29.6 | 6 | 11.1 | 8 | 14.8 |
| Glasgow | 61 | 21 | 5 | 23.8 | 3 | 14.3 | 3 | 14.3 | 5 | 23.8 | 2 | 9.5 | 3 | 14.3 |
| Great Falls | 164 | 27 | 6 | 22.2 | 6 | 22.2 | 3 | 11.1 | 3 | 11.1 | 1 | 3.7 | 8 | 29.7 |
| Helena | 24 | 11 | 3 | 27.3 | 0 | 0 | 1 | 9.1 | 2 | 18.2 | 0 | 0 | 5 | 45.4 |
| Kalispell | 78 | 42 | 8 | 19.0 | 7 | 16.7 | 9 | 21.4 | 10 | 23.8 | 3 | 7.2 | 5 | 11.9 |
| Miles City | 128 | 47 | 11 | 23.4 | 7 | 14.9 | 8 | 17.0 | 10 | 21.3 | 5 | 10.6 | 6 | 12.8 |
| Missoula | 85 | 34 | 7 | 20.6 | 6 | 17.6 | 5 | 14.7 | 6 | 17.6 | 0 | 0 | 10 | 29.5 |
| TOTALS | 891 | 314 | 66 | 21.0 | 48 | 15.3 | 49 | 15.6 | 63 | 20.1 | 19 | 6.1 | 69 | 21.9 |

physicians with respect to the number of their patients who were not treated because facilities or services were not available to them.

The services of the non-psychiatric physician can be extremely important to the community that lacks psychiatric resources. In a study of community resources, sponsored by the Joint Commission, "without exception" the non-psychiatric physicians interviewed reported the presence of emotionally disturbed persons among their patients. The following quotation is of interest and correlates closely with information obtained from Montana physicians:[1]

> Nearly all doctors reported a considerable number of mentally ill or emotionally disturbed patients. Several doctors estimated that as many as 75 percent of their patients were emotionally disturbed.

Most physicians in Montana seem favorably disposed toward the community psychiatric facility and some are active in promoting better mental health services to their communities.

## GENERAL HOSPITALS

The number of general hospitals offering services to the psychiatric patient has increased with the influx of psychiatrists in private practice into Montana. Three hospitals presently have psychiatric units within their complexes. These hospitals, located at Billings, Great Falls, and Missoula, are considered below. (See Map 4.12) In addition, new hospital construction planned for Helena provides for six beds to be utilized by the psychiatric or agitated patient.

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[1] Reginald Robinson, David F. DeMarche, and Mildred K. Wagle, Community Resources in Mental Health, A Report Prepared by the Joint Commission on Mental Illness and Health, (New York: Basic Books, Inc., 1960), p. 301.

BILLINGS DEACONESS HOSPITAL
BILLINGS, MONTANA

Patients are housed in a separate and designated psychiatric unit. They may also be housed on non-psychiatric wards in a standard medical facility. Patients are admitted informally without written application and are not excluded on the basis of their diagnostic or symptom category. General practitioners are permitted to admit and treat patients for mental illness; however, they do so with the benefit of consultation with a psychiatrist.

The physical facilities available to the psychiatric patient are as follows: multi-purpose room, physical examination room, and one seclusion room. In terms of security, the facility would be classified "substantially closed". However, this varies from one patient to the next according to individual treatment needs. During day-time hours, patients are allowed to wear street clothing.

The hospital provides 24-hour emergency service, but has no provision for any kind of after-care treatment, viz., a half-way house. The hospital staff does provide outpatient service. Part-time hospitalization is provided in the form of night hospitalization.

Table 5.12 shows to what extent different therapeutic programs are used by the five private psychiatrists in Billings. Four psychiatrists are on the hospital's active attending staff, and one psychiatrist is on the hospital courtesy staff, with privilege of admitting patients.

Table 5.13 indicates the kinds and numbers of staff persons employed by the hospital who are assigned to the care of psychiatric patients.

TABLE 5.12

BILLINGS DEACONESS HOSPITAL THERAPEUTIC PROGRAM

| TYPES OF THERAPY | | FREQUENTLY | OCCASIONALLY | INFREQUENTLY OR NOT AT ALL |
|---|---|---|---|---|
| Individual Psychotherapy: | | | | |
| | by patient's private doctor | x | | |
| | by hospital-employed doctor | | | x |
| Group Psychotherapy - conducted by: | | | | |
| | psychiatrist | | x | |
| | psychologist | | | x |
| | social worker | | | x |
| | psychiatric nurse | | | x |
| | other | | | |
| Chemotherapy | | x | | |
| Electroshock | | x | | |
| Insulin coma | | | | x |
| Insulin sub-coma | | | x | |
| Planned and supervised recreational therapy | | | x | |
| Planned and supervised occupational therapy | | | x | |

TABLE 5.13

BILLINGS DEACONESS HOSPITAL TREATMENT PERSONNEL

| PERSONNEL | NUMBER FULL-TIME | NUMBER PART-TIME | TOTAL FULL-TIME EQUIVALENCY |
|---|---|---|---|
| Psychiatrists | - | - | - |
| Psychiatric Residents | - | - | - |
| Social Workers | - | - | - |
| Registered Nurses | 3 | - | 3 |
| Licensed Practical Nurses | 1 | - | 1 |
| Occupational Therapist Reg. | - | - | - |
| Aides, Attendants | 6 | 1 | $6\frac{1}{2}$ |

The basic charge for the psychiatric patient is $20.00 per day for a private room. In addition to room and board, this charge includes: recreational, occupational, and other ancillary therapy. Of all psychiatric patients admitted, 55 percent are estimated to have insurance which covers part or all of their charges. For those patients who carry insurance, the following breakdown has been estimated by the hospital to by the degree of coverage:[1]

75 percent are covered for 2/3 or more of their charges
13 percent are covered for 1/3 to 2/3 of their charges
12 percent are covered for 1/3 or less of their charges

Of the total patients admitted to the hospital's psychiatric unit in 1963, 78 percent were first admissions. Fifteen percent of all admissions were transferred to other facilities. The following is a breakdown of these transfers: 10 percent went to a state mental hospital; three percent went to private mental hospitals; and two percent to rest homes or nursing homes. The average length of stay per discharged patient was 15 days.

A program of instruction is sponsored by the psychiatric service for the nurses and the aides. The hospital does not have an affiliation with a medical school.

## MONTANA DEACONESS HOSPITAL
## GREAT FALLS, MONTANA

Patients are housed in a separate and designated psychiatric unit. They may also be housed on non-psychiatric wards in a standard medical facility. Patients are admitted informally without written application

[1]The percentages reported as degrees of coverage are merely estimates as reported to the project office by the hospitals concerned. The figures should not, therefore, be interpreted as information having record reliability.

and are not excluded on the basis of their diagnostic or symptom category. General practitioners are permitted to admit and treat patients for mental illness. General practitioners are not required to consult with or be supervised by a psychiatrist in the treatment process.

The physical facilities available to the psychiatric patient are as follows: day room, dining room, multi-purpose room, and separate occupational therapy shop. In terms of security, this facility would be classified "substantially closed". However, this varies from one patient to the next according to individual treatment needs. During day-time hours, patients are allowed to wear street clothing.

The hospital provides 24-hour emergency service, but has no provision for any kind of after-care treatment, viz., a half-way house. The hospital staff does provide outpatient service. Part-time hospitalization is provided for day as well as night periods.

Table 5.14 shows to the extent different therapeutic programs are used by the four private psychiatrists in Great Falls. All of these psychiatrists are on the hospital's active attending staff.

Table 5.15 indicates the position classification and numbers of staff persons employed by the hospital who are assigned to the care of psychiatric patients.

The basic charge for psychiatric patients is $25.75 a day for either private or double room. This cost includes board and room, group psychotherapy and occupational therapy. Of all psychiatric patients admitted, 45 percent are estimated to have insurance which covers all or part of their charges. For those patients who carry insurance, the following

TABLE 5.14

MONTANA DEACONESS HOSPITAL THERAPEUTIC PROGRAM

| TYPES OF THERAPY | | FREQUENTLY | OCCASIONALLY | INFREQUENTLY OR NOT AT ALL |
|---|---|---|---|---|
| Individual Psychotherapy: | | | | |
| | by patient's private doctor | x | | |
| | by hospital-employed doctor | | | x |
| Group Psychotherapy - conducted by: | | | | |
| | psychiatrist | | | x |
| | psychologist | | | x |
| | social worker | | | x |
| | psychiatric nurse | | | x |
| | other | | | |
| Chemotherapy | | x | | |
| Electroshock | | x | | |
| Insulin coma | | | | x |
| Insulin sub-coma | | | x | |
| Planned and supervised recreational therapy | | | x | |
| Planned and supervised occupational therapy | | x | | |

TABLE 5.15

MONTANA DEACONESS HOSPITAL TREATMENT PERSONNEL

| PERSONNEL | NUMBER FULL-TIME | NUMBER PART-TIME | TOTAL FULL-TIME EQUIVALENCY |
|---|---|---|---|
| Psychiatrists | - | - | - |
| Psychiatric Residents | - | - | - |
| Social Workers | - | - | - |
| Registered Nurses | 7 | 1 | $7\frac{1}{2}$ |
| Licensed Practical Nurses | 2 | - | 2 |
| Occupational Therapist Reg. | - | 1 | $\frac{1}{4}$ |
| Aides, Attendants | 8 | - | 8 |
| Other - Ward Clerks | 1 | - | 1 |

breakdown has been estimated by the hospital to be the degree of coverage:

95 percent are covered for 2/3 or more of their charges
5 percent are covered for 1/3 to 2/3 of their charges
0 percent are covered for 1/3 or less of their charges

Of the total patients admitted to this hospital's psychiatric unit in 1963, 51.8 percent were first admissions. Of all admissions, 5.2 percent were transferred to other facilities; in this instance, all were transferred to a state mental hospital. The average length of stay per discharged patient was 12 days.

A program of instruction is sponsored by the psychiatric service for the nurses and aides. The hospital does not have an affiliation with a medical school.

## ST. PATRICK HOSPITAL
## MISSOULA, MONTANA

Patients are housed in ordinary medical facilities. These patients are admitted informally or without written application. Assaultive, agitated or uncooperative behavioral patients are excluded from admission. General practitioners are permitted to admit and treat patients for mental illness; however, they do so with the benefit of consultation with a psychiatrist.

The physical facilities included for psychiatric patients are the same as for general patient care. Two seclusion rooms are available for temporary use to care for the patient who becomes agitated. In terms of security, this facility would be classified "substantially open". Patients wear pajamas and bathrobe.

The hospital provides 24-hour emergency service, but has no provision for any kind of after-care treatment, viz., a half-way house. The hospital staff does provide limited outpatient service.

Table 5.16 shows to what extent different therapeutic programs are used by the one private psychiatrist in Missoula. This psychiatrist is on the hospital's active attending staff.

TABLE 5.16

ST. PATRICK HOSPITAL THERAPEUTIC PROGRAM

| TYPES OF THERAPY | FREQUENTLY | OCCASIONALLY | INFREQUENTLY OR NOT AT ALL |
|---|---|---|---|
| Individual Psychotherapy: | | | |
| by patient's private doctor | x | | |
| by hospital-employed doctor | | | x |
| Group Psychotherapy - conducted by: | | | |
| psychiatrist | | | x |
| psychologist | | | x |
| social worker | | | x |
| psychiatric nurse | | | x |
| other | | | |
| Chemotherapy | x | | |
| Electroshock | x | | |
| Insulin coma | | | x |
| Insulin sub-coma | | | x |
| Planned and supervised recreational therapy | | | x |
| Planned and supervised occupational therapy | | | x |

The position classifications and numbers of staff persons employed are the same as the staffing for general hospital patients.

The basic daily charge for psychiatric patients is $23.50 to $27.50 a single room, and $21.50 for a double room. Of all psychiatric patients admitted, 10 percent are estimated to have insurance which covers part of their charges. For those patients who are covered by insurance, the following breakdown has been estimated by the hospital to be the degree of coverage:

0 percent are covered for 2/3 or more of their charges
0 percent are covered for 1/3 to 2/3 of their charges
100 percent are covered for 1/3 or less of their charges

Of the total patients admitted to this hospital's psychiatric unit in 1963, 93 percent were first admissions. Of all admissions, 2.4 percent were transferred to other facilities. The following is a breakdown of these transfers: 1.6 percent went to a state mental hospital; .8 percent wernt to private mental hospitals; and none to rest homes or nursing homes. The average length of stay per discharged patient is five days.

This hospital has no specific training program for psychiatric nurses or aides. This hospital does not have an affiliation with a medical school.

CHAPTER VI

## SUPPORTIVE FACILITIES AND RESOURCES

### DEPARTMENT OF PUBLIC WELFARE

#### Old Age Assistance

The Old Age Assistance program provides an income to needy persons 65 years of age and over to supplement their own resources. For many years this was the largest assistance program in the state. However, more recently there has been a noticeable decrease in Montana's Old Age Assistance case load. (See Table 6.1 showing OAA by county for August 1964 compared with the same month in 1963 and in 1959.) This downward trend has continued at about the same rate from year to year. "As of July 1, 1962, the case load was 6,135 persons. It declined to 5,399 persons on July 1, 1964."[1] The Social Security program accounts for this continued decline.

Although the case load dropped by six percent from August 1963 to August 1964, concurrently the total expenditures in the program only dropped by 1.2 percent. This undoubtedly is attributable to the recognized rise in the cost of living, and subsequent increase in the average amount allocated per case.

Each county in Montana is served by a Family Service staff. The staffing is shown on Table 6.2 by level of employment and academic degree.

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[1] State Department of Public Welfare, Report To The Honorable Tim Babcock, Governor Of The State of Montana, for the Period Beginning July 1, 1962, and Terminating June 30, 1964, p. 9.

TABLE 6.1

OLD AGE ASSISTANCE BY COUNTY, AUGUST 1964
COMPARED WITH SAME MONTH LAST YEAR
AND FIVE YEARS AGO

| COUNTY | AUGUST 1964 | | | AUGUST 1963 | | AUGUST 1959 | |
|---|---|---|---|---|---|---|---|
| | NUMBER OF CASES | AMOUNT | AVERAGE PER CASE | NUMBER OF CASES | AVERAGE PER CASE | NUMBER OF CASES | AVERAGE PER CASE |
| TOTAL . . . | 5,381 | $384,856.00 | $ 71.52 | 5,726 | $68.00 | 7,226 | $62.92 |
| Beaverhead . . . | 67 | 4,405.00 | 65.75 | 68 | 68.03 | 118 | 67.17 |
| Big Horn . . . . | 108 | 7,704.00 | 71.33 | 114 | 70.13 | 136 | 61.10 |
| Blaine . . . . . | 92 | 6,777.00 | 73.66 | 87 | 70.66 | 141 | 63.44 |
| Broadwater . . . | 27 | 1,841.00 | 68.19 | 24 | 64.17 | 34 | 57.56 |
| Carbon . . . . . | 117 | 7,896.00 | 67.49 | 126 | 65.90 | 184 | 60.28 |
| Carter . . . . . | 36 | 3,150.00 | 87.50 | 37 | 87.30 | 63 | 69.75 |
| Cascade . . . . | 495 | 34,596.00 | 69.89 | 518 | 65.49 | 579 | 62.93 |
| Chouteau . . . . | 51 | 3,765.00 | 73.82 | 52 | 66.67 | 57 | 65.65 |
| Custer . . . . . | 141 | 10,268.00 | 72.82 | 142 | 68.83 | 189 | 61.86 |
| Daniels . . . . | 35 | 2,802.00 | 80.06 | 35 | 77.49 | 39 | 63.79 |
| Dawson . . . . . | 74 | 5,505.00 | 74.39 | 73 | 72.84 | 93 | 63.54 |
| Deer Lodge . . . | 67 | 4,514.00 | 67.37 | 80 | 66.29 | 92 | 64.51 |
| Fallon . . . . . | 26 | 2,138.00 | 82.23 | 32 | 73.00 | 47 | 73.38 |
| Fergus . . . . . | 169 | 12,627.00 | 74.72 | 188 | 69.19 | 223 | 65.42 |
| Flathead . . . . | 295 | 20,804.00 | 70.52 | 333 | 66.70 | 393 | 61.44 |
| Gallatin . . . . | 123 | 8,946.00 | 72.73 | 126 | 67.11 | 191 | 59.88 |
| Garfield . . . . | 9 | 774.00 | 86.00 | 11 | 72.91 | 27 | 67.41 |
| Glacier . . . . | 151 | 10,873.00 | 72.01 | 150 | 70.07 | 147 | 68.42 |
| Golden Valley . | 12 | 921.00 | 76.75 | 14 | 70.14 | 22 | 63.45 |
| Granite . . . . | 14 | 847.00 | 60.50 | 20 | 58.05 | 36 | 58.36 |
| Hill . . . . . | 131 | 9,212.00 | 70.32 | 139 | 67.78 | 149 | 61.50 |
| Jefferson . . . | 42 | 3,055.00 | 72.74 | 42 | 72.38 | 47 | 72.64 |
| Judith Basin . . | 42 | 2,870.00 | 68.33 | 42 | 66.98 | 62 | 65.90 |
| Lake . . . . . | 170 | 11,407.00 | 67.10 | 193 | 63.91 | 204 | 59.70 |
| Lewis & Clark . . | 169 | 11,962.00 | 70.78 | 190 | 65.80 | 233 | 60.30 |
| Liberty . . . . | 7 | 709.00 | 101.29 | 7 | 94.29 | 9 | 78.56 |
| Lincoln . . . . | 98 | 6,378.00 | 65.08 | 103 | 63.06 | 146 | 55.73 |
| Madison . . . . | 88 | 6,147.00 | 69.85 | 90 | 64.92 | 135 | 60.17 |
| McCone . . . . . | 14 | 1,079.00 | 77.07 | 17 | 69.06 | 32 | 58.12 |
| Meagher . . . . | 34 | 2,234.00 | 65.71 | 42 | 62.67 | 55 | 67.35 |
| Mineral . . . . . | 27 | 1,927.00 | 71.37 | 28 | 71.00 | 46 | 61.61 |
| Missoula . . . . | 277 | 19,844.00 | 71.64 | 283 | 67.06 | 355 | 59.44 |
| Musselshell . . | 54 | 3,568.00 | 66.07 | 54 | 66.67 | 83 | 59.12 |
| Park . . . . . | 104 | 6,734.00 | 64.75 | 106 | 64.07 | 148 | 59.20 |
| Petroleum . . . . | 6 | 528.00 | 88.00 | 7 | 69.57 | 12 | 62.58 |
| Phillips . . . . | 84 | 6,094.00 | 72.55 | 87 | 70.10 | 107 | 62.26 |
| Pondera . . . . | 75 | 5,835.00 | 77.80 | 76 | 73.12 | 68 | 68.62 |
| Powder River . . | 10 | 771.00 | 77.10 | 16 | 65.12 | 26 | 60.69 |
| Powell . . . . | 54 | 3,272.00 | 60.59 | 58 | 64.47 | 82 | 66.43 |
| Prairie . . . . | 30 | 2,043.00 | 68.10 | 33 | 61.15 | 41 | 63.49 |
| Ravalli . . . . | 165 | 12,204.00 | 73.96 | 189 | 72.79 | 240 | 65.88 |
| Richland . . . . | 118 | 8,329.00 | 70.58 | 121 | 67.00 | 144 | 63.08 |
| Roosevelt . . . | 151 | 11,283.00 | 74.72 | 146 | 72.23 | 136 | 61.26 |
| Rosebud . . . . | 92 | 6,827.00 | 74.21 | 101 | 69.81 | 119 | 67.33 |
| Sanders . . . . | 99 | 7,288.00 | 73.62 | 108 | 69.81 | 149 | 62.58 |
| Sheridan . . . . | 71 | 6,080.00 | 85.63 | 80 | 76.49 | 81 | 70.59 |
| Silver Bow . . . | 376 | 26,866.00 | 71.45 | 396 | 67.08 | 540 | 62.88 |
| Stillwater . . . | 37 | 2,754.00 | 74.43 | 42 | 68.86 | 67 | 64.84 |
| Sweet Grass . . . | 35 | 2,325.00 | 66.43 | 43 | 62.49 | 58 | 60.26 |
| Teton . . . . . | 61 | 4,285.00 | 70.25 | 62 | 69.19 | 70 | 67.97 |
| Toole . . . . . | 36 | 2,523.00 | 70.08 | 40 | 64.52 | 50 | 61.22 |
| Treasure . . . . | 10 | 788.00 | 78.80 | 10 | 74.60 | 19 | 69.47 |
| Valley . . . . . | 80 | 5,925.00 | 74.06 | 87 | 73.06 | 121 | 65.75 |
| Wheatland . . . . | 31 | 2,139.00 | 69.00 | 33 | 66.39 | 49 | 60.57 |
| Wibaux . . . . . | 19 | 1,311.00 | 69.00 | 22 | 63.86 | 26 | 59.31 |
| Yellowstone . . . | 375 | 27,107.00 | 72.29 | 403 | 68.24 | 506 | 64.08 |

TABLE 6.2 *

FAMILY SERVICE STAFFING
BY LEVEL OF EMPLOYMENT AND ACADEMIC DEGREE

| LEVEL OF EMPLOYMENT | BELOW COLLEGE GRADUATE | COLLEGE GRADUATE | ONE YEAR PROFESSIONAL TRAINING | MASTERS DEGREE IN SOCIAL WORK |
|---|---|---|---|---|
| State Level | 0 | 4 | 0 | 1 |
| Field Supervisor | 0 | 3 | 1 | 2 |
| County Level | 28 | 98 | 3 | 7 |
| TOTALS | 28 | 105 | 4 | 10 |

* Information supplied by State Department of Public Welfare, Family Services Division, as of January 1, 1965.

This year, and in succeeding years, more emphasis will be placed on additional service to the aged. As more trained social work personnel are employed, the public assistance program will offer therapeutic assistance to those who, in addition to monetary aid, need help for emotional disturbances. A more comprehensive program of assistance will aid the mental patient who has been released back into the community.

Intensive training and staff development are underway through special training sessions being conducted in university settings and through the educational stipend program as described in the Chapter on Manpower.[1] Eleven openings are available under this stipend program. Some of these positions are already filled by candidates who have been accepted by approved schools of social work.[2]

[1] Supra, pp. 162-164.

[2] Conference with Department of Public Welfare, March 2, 1965.

Each county's Family Service agency should be geared to programs providing supportive services to the aged who are mentally and emotionally unstable. Often these individuals live alone in humble circumstances and on a mere sustenance diet. Meager circumstances and emotional disorder are often companionate, and simple augmentation of the physiological needs is not sufficient in many instances to allow the individual to maintain an acceptable level of social functioning. County Family Service staffs visit individuals on Old Age Assistance. This practice should receive greater encouragement and support.

Table 6.3 shows the average individual monthly payment in Montana as compared with the national average. (Figures are given for the month of July.)

TABLE 6.3

OLD AGE ASSISTANCE PAYMENTS

| MONTH | YEAR | AVERAGE INDIVIDUAL PAYMENT | NATIONAL AVERAGE |
|---|---|---|---|
| July | 1960 | $63.55 | $58.09 |
| July | 1962 | $65.25 | $58.14 |
| July | 1964 | $71.56 | $61.51 |

Child Welfare

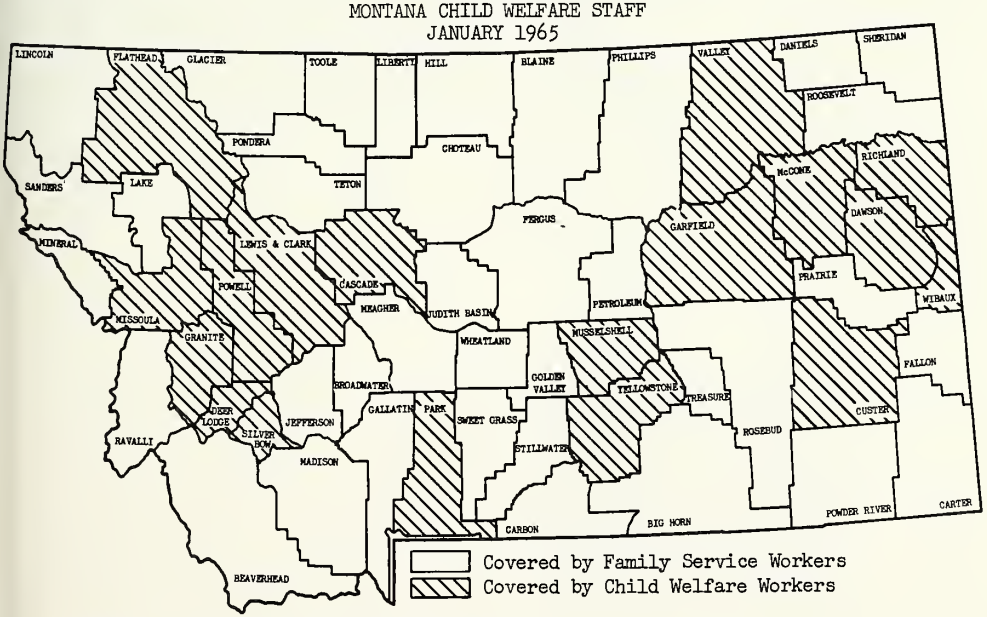
"Thirty-seven percent of the nation's counties . . . . have no child welfare services of any sort, and 49 percent of those that do (containing a fourth of the country's children) lack public and welfare services."[1]

[1]Joint Commission on Mental Illness and Health, Action for Mental Health, Final Report (New York: Basic Books, Inc., 1961), p. 115.

All of Montana's 56 counties have child welfare services furnished either by Child Welfare Service staff or by Family Service staff. Map 6.1 shows the location of county welfare offices where full-time services are provided by a Child Welfare Service staff. All other counties are served by part-time Family Service staff. Approximately 80 percent of the Child Welfare Service cases have full-time service coverage. There are approximately 1,200 new cases admitted each year into the Child Welfare program.

MAP 6.1

COUNTIES SERVED BY
MONTANA CHILD WELFARE STAFF
JANUARY 1965




NOTE: Both Family Service Workers and Child Welfare Workers are supervised by field supervisors who have Masters Degrees in Social Work.

The most pressing need felt by the Child Welfare Service staff is for a diagnostic, evaluation and treatment program. Hopefully, this program would be carried out as close to the individual's home community as possible. The importance of day care and homemaker service are recognized as important programs in maintaining children in their home environment.

Child Welfare Service staffing by level of employment and academic degree is shown in Table 6.4.

TABLE 6.4

CHILD WELFARE SERVICE STAFFING
BY LEVEL OF EMPLOYMENT AND ACADEMIC DEGREE

| LEVEL OF EMPLOYMENT | BELOW COLLEGE GRADUATE | COLLEGE GRADUATE | ONE YEAR PRO-FESSIONAL TRAINING | MASTERS DEGREE IN SOCIAL WORK |
|---|---|---|---|---|
| State Level | 0 | 0 | 0 | 2 |
| Field Supervisor | 0 | 0 | 0 | 6 |
| County Level | 0 | 17 | 3 | 5 |
| TOTALS | 0 | 17 | 3 | 13 |

> The 1960 census reported Montana's child population as 286,094 children under the age of 21 years. During the period of the biennium beginning with July 1, 1962, and ending June 30, 1964, a total of 4,815 children received child welfare services through the State and County Departments of Public Welfare. Through the services given during the period, 3,603 cases were closed. At the end of the period there were 1,212 active cases. Of the children receiving services as of June 30, 1964, there were: 568 at home with their parents; 69 in the homes of relatives; 333 resided in foster homes; 144 were in adoptive homes; 58 were in child caring institutions, and 40 were in other care facilities, including hospitals.[1]

[1] State Department of Public Welfare, Report To The Honorable Tim Babcock, Governor Of The State Of Montana, For the Period Beginning July 1, 1962 and Terminating June 30, 1964, p. 10.

Table 6.5 is a comparative listing of active child welfare cases by county for the months of June 1962 and June 1964.[1]

TABLE 6.5

CHILD WELFARE CASES
BY COUNTY
JUNE 1962, JUNE 1964

| COUNTY | JUNE 1964 | JUNE 1962 | COUNTY | JUNE 1964 | JUNE 1962 |
|---|---|---|---|---|---|
| Beaverhead | 5 | 6 | McCone | 8 | - |
| Big Horn | 4 | 3 | Meagher | 2 | 1 |
| Blaine | 18 | 3 | Mineral | 8 | 6 |
| Broadwater | 3 | 3 | Missoula | 33 | 46 |
| Carbon | 14 | 17 | Musselshell | 49 | 53 |
| Carter | 1 | - | Park | 34 | 34 |
| Cascade | 150 | 203 | Petroleum | 1 | - |
| Chouteau | 10 | 7 | Phillips | 14 | 10 |
| Custer | 38 | 52 | Pondera | 2 | 1 |
| Daniels | - | - | Powder River | - | 3 |
| Dawson | 8 | 9 | Powell | 10 | - |
| Deer Lodge | 34 | 18 | Prairie | 5 | 5 |
| Fallon | 2 | 2 | Ravalli | 22 | 25 |
| Fergus | 18 | 14 | Richland | 3 | 2 |
| Flathead | 45 | 46 | Roosevelt | 10 | 5 |
| Gallatin | 28 | 29 | Rosebud | 8 | 4 |
| Garfield | - | - | Sanders | 3 | 9 |
| Glacier | 19 | 25 | Sheridan | 1 | 1 |
| Golden Valley | - | - | Silver Bow | 144 | 114 |
| Granite | 4 | 4 | Stillwater | 6 | 1 |
| Hill | 9 | 24 | Sweet Grass | 5 | 18 |
| Jefferson | 10 | 2 | Teton | 11 | 2 |
| Judith Basin | - | 1 | Toole | 10 | 3 |
| Lake | 19 | 14 | Treasure | - | 1 |
| Lewis & Clark | 77 | 82 | Valley | 37 | 27 |
| Liberty | - | 2 | Wheatland | 3 | 2 |
| Lincoln | 6 | 11 | Wibaux | - | 6 |
| Madison | 11 | 10 | Yellowstone | 171 | 194 |
| | | | TOTALS . . . | 1,212 | 1,233 |

[1] Ibid, p. 10.

The Aid to Dependent Children case number in Montana has not fluctuated greatly between fiscal years 1962 and 1964. The average individual payment for July is reported in Table 6.6.

TABLE 6.6

AID TO DEPENDENT CHILDREN
FOR
JULY 1960, 1962 AND 1964

| MONTH | YEAR | AVERAGE INDIVIDUAL PAYMENT | NATIONAL AVERAGE |
|---|---|---|---|
| July | 1960 | $32.91 | $29.22 |
| July | 1962 | $34.05 | $29.26 |
| July | 1964 | $35.20 | $32.77 |

## CHURCHES

The role of the church in Montana's comprehensive mental health program cannot be overlooked. All clergymen engage in pastoral counseling to some degree and play an important role as a community resource for the mentally ill. In a national study it was found that people in trouble most frequently (42 percent) consulted clergymen as a source of advice.[1] Considering Montana's large geographic area and dearth of social agencies in the family counseling area, the percent is estimated to be somewhat higher in this state.

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[1] Gerald Gurin, Joseph Veroff and Sheila Feld, Americans View Their Mental Health, Monograph Series No. 4, (Joint Commission on Mental Illness and Health, 1960), p. 307.

In Montana, 518 churches cooperated partially or fully in furnishing information on a community survey. Of the 518 reporting churches, 74.7 percent favored referral of members of their congregations, who may be mentally disturbed, to professional resources. In reply to this question, 6.9 percent of the clergymen answered "no".

Several clergymen would have favored referral of their church members to psychiatrists and clinics providing they knew the psychiatrists or clinic staff members. There seemed to be some concern on the part of some clergymen that referral might result in turning the individual away from his religious orientation.

Clergymen indicated strong interest in mental health and pastoral case counseling seminars. They indicated they would prefer to have these seminars conducted closer to their home districts. Several, particularly in eastern Montana, indicated that seminars in Great Falls and Billings were situated too far from the area they service, and felt that long distances to travel would prevent many from attending. Nearly 41 percent reported having attended seminars on pastoral counseling -- these seminars were primarily sponsored by their own faith. Clergymen also reported attendance at mental health seminars sponsored by the Montana Mental Health Association. About 73 percent of the clergymen favored additional mental health consultation and facilities in their areas. Many noted a total lack of referral agencies in their areas and felt the need for assistance from psychiatric resources in their communities.

Churches indicated that something over 70 percent have active organizations centered around youth covering ages 8 - 19. However, 38 percent reported no organizations centered around the aged group. One

clergyman stated: "We are aware of the need for a definite and regular program for the elderly of our church, and we are working at it". Many others propounded this same idea and gave indication of their interest in doing more for the aged.

Because of the absence of other resources in the community, the clergymen in Montana will continue to play an important role in supporting the emotionally ill in their communities.[1]

1. The clergy can provide spiritual support to emotionally disturbed people in times of stress and crisis.

2. The clergy can counsel on religious matters, applying all the psychological insight at their disposal.

3. The clergy can "listen" and identify cases with problems outside the religious framework, and refer them to proper community resources.

There are approximately 235,000 clergymen in the United States. According to a recent study, an estimated eight or nine thousand have taken formal courses in clinical pastoral counseling.[2]

Assuming that Montana is near the national statistic as to number of clergymen per psychiatrist, it would appear that there are approximately 700 clergymen throughout the state in contrast to the 21 psychiatrists available. Thus, there is a great potential for counseling the emotionally disturbed in the state's group of clergy.

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[1] Reginald Robinson, David F. DeMarche and Mildred K. Wagle, Community Resources in Mental Health (New York: Basic Books, Inc., 1960), pp. 248-249.

[2] Joint Commission on Mental Illness and Health, Action for Mental Health, Final Report (New York: Basic Books, Inc., 1961), p. 135.

## SCHOOLS

"Next to the family, the school is probably the most important unit of society as far as the protection of mental health is concerned."[1] It is mandatory for the child to attend school, thus making this experience almost universal. An age and sex pyramid of Montana's population growth from 1950-1960 is shown on Table 2.2 in the Chapter on Demographic Analysis.[2]

Through intelligent use of school counselors, psychologists, school nurses, and school social workers, children with problems can be effectively helped by the school system. It is not financially feasible for all school systems in Montana to provide these complete pupil personnel services. It is feasible, however, that through cooperation between school districts, partial service could be afforded to all school children of Montana.

In Montana there are now 867 operating school districts, only one of which employs a psychologist in a program of school testing, and this is only a part-time program. School psychologists are in short supply in most areas of the country, but in Montana, the shortage is even more acute. A qualified testing program can provide a means of proper "categorization" of those students with any of several kinds of problems. The slow learners, as well as the children with mental retardation, could be found and their problems recognized; and if such testing were available, the children could be given the special help that their particular cases might indicate.

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[1] Reginald Robinson, David F. DeMarche, and Mildred K. Wagle, Community Resources in Mental Health, Monograph Series No. 5, Joint Commission on Mental Illness and Health, (New York: Basic Books, Inc., 1960), p. 154.

[2] Supra, p. 29.

In the 1965 Legislature, House Bill No. 62 was introduced to make available to the State Department of Public Instruction the services of two psychologists whose function would be to offer limited testing services to Montana's school districts. However, the bill was killed on the basis of financial non-feasibility. (See Appendix C for copy of House Bill No. 62) Presently neither the State Department of Public Instruction nor any Montana professional association has established criteria for school psychologists. However, on the assumption that eligibility standards would help insure qualified staffs and better programs when and if these become feasible for Montana, planning is underway for State Board of Education recognition of school psychologists, licensed by the appropriate professional association on the basis of professional association standards.[1]

There are no school districts in Montana which employ a school social worker. Thirty-three of the 56 counties have public health nurses providing services to the schools.

School guidance counselors are available to a majority of our students at the secondary level of education; recent expansion of

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[1]Note: Statutes prescribe that the State Board of Education shall prescribe and adopt rules and regulations for the issuance of all certificates for teaching . . . . teaching personnel include instructional, supervisory and administrative staff.

In accordance with the statutes, and because it is not in a position to specify professional standards for other disciplines, the State Board has adopted a policy of recognizing professional association standards for school-related personnel who are not directly involved in teaching situations that lead to the granting of credits and promotions, i.e., Speech & Hearing Therapists, etc.

National Defense Education Act assistance for elementary guidance programs is expected to extend counseling service. School counselors provide a substantial resource for identifying children who have problems. The State Department of Public Instruction maintains a record of public school counselors and their degree of qualification. The following tables (6.7, 6.8, 6.9, 6.10 and 6.11) tabulate this information and indicate geographic distribution. Qualifications of non-public school counselors have not been recorded; therefore these persons are listed under the "Unknown" column. This listing includes many counselors who are well qualified as well as those who have little or no training in counseling; it should not be assumed therefore that "Unknown" connotes no training.

TABLE 6.7

NUMBER OF COUNSELORS
AND DEGREE OF QUALIFICATION
1965

| AGENCY | QUALIFICATION | | | | TOTAL COUNSELORS |
|---|---|---|---|---|---|
| | NO SPECIAL TRAINING | 15 QUARTER HOURS | 30 QUARTER HOURS | UNKNOWN | |
| Non-Public High Schools | - | - | - | 44 | 44 |
| Public High Schools | 40 | 58 | 132 | - | 230 |
| Accredited Jr. High Sc. | 4 | 11 | 38 | - | 53 |
| TOTALS | 88 | 70 | 168 | 44 | 327 |

TABLE 6.8

NUMBER OF COUNSELORS AND DEGREE OF QUALIFICATION
IN NON-PUBLIC HIGH SCHOOLS
BY COMPREHENSIVE MENTAL HEALTH DISTRICTS AND SUB-DISTRICTS
1965

| NON-PUBLIC HIGH SCHOOLS | QUALIFICATION | TOTAL |
|---|---|---|
| | UNKNOWN | COUNSELORS |
| BILLINGS COMPREHENSIVE DISTRICT | 10 | 10 |
| Miles City Sub-District | 2 | 2 |
| Billings Sub-District | 5 | 5 |
| Bozeman Sub-District | 3 | 3 |
| GREAT FALLS COMPREHENSIVE DISTRICT | 21 | 21 |
| Glasgow Sub-District | 2 | 2 |
| Great Falls Sub-District | 16 | 16 |
| Helena Sub-District | 3 | 3 |
| MISSOULA COMPREHENSIVE DISTRICT | 13 | 13 |
| Kalispell Sub-District | - | - |
| Missoula Sub-District | 7 | 7 |
| Butte Sub-District | 6 | 6 |
| TOTALS | 44 | 44 |

TABLE 6.9

NUMBER OF COUNSELORS AND DEGREE OF QUALIFICATION
IN PUBLIC HIGH SCHOOLS
BY COMPREHENSIVE MENTAL HEALTH DISTRICTS AND SUB-DISTRICTS
1965

| PUBLIC HIGH SCHOOLS | QUALIFICATION | | | TOTAL COUNSELORS |
|---|---|---|---|---|
| | NO SPECIAL TRAINING | 15 QUARTER HOURS | 30 QUARTER HOURS | |
| BILLINGS COMPREHENSIVE DISTRICT | 15 | 21 | 46 | 82 |
| Miles City Sub-District | 7 | 6 | 11 | 24 |
| Billings Sub-District | 6 | 11 | 25 | 42 |
| Bozeman Sub-District | 2 | 4 | 10 | 16 |
| GREAT FALLS COMPREHENSIVE DISTRICT | 13 | 24 | 55 | 92 |
| Glasgow Sub-District | 5 | 9 | 18 | 32 |
| Great Falls Sub-District | 8 | 13 | 31 | 52 |
| Helena Sub-District | - | 2 | 6 | 8 |
| MISSOULA COMPREHENSIVE DISTRICT | 12 | 13 | 31 | 56 |
| Kalispell Sub-District | 3 | 4 | 10 | 17 |
| Missoula Sub-District | 8 | 7 | 15 | 30 |
| Butte Sub-District | 1 | 2 | 6 | 9 |
| TOTALS | 40 | 58 | 132 | 230 |

TABLE 6.10

NUMBER OF COUNSELORS AND DEGREE OF QUALIFICATION
IN ACCREDITED JUNIOR HIGH SCHOOLS
BY COMPREHENSIVE MENTAL HEALTH DISTRICTS AND SUB-DISTRICTS
1965

| ACCREDITED JUNIOR HIGH SCHOOLS | QUALIFICATION | | | TOTAL COUNSELORS |
|---|---|---|---|---|
| | NO SPECIAL TRAINING | 15 QUARTER HOURS | 30 QUARTER HOURS | |
| BILLINGS COMPREHENSIVE DISTRICT | 2 | 2 | 15 | 19 |
| Miles City Sub-District | - | - | 1 | 1 |
| Billings Sub-District | 2 | 1 | 11 | 14 |
| Bozeman Sub-District | - | 1 | 3 | 4 |
| GREAT FALLS COMPREHENSIVE DIST. | 1 | 7 | 17 | 25 |
| Glasgow Sub-District | - | - | - | - |
| Great Falls Sub-District | 1 | 7 | 14 | 22 |
| Helena Sub-District | - | - | 3 | 3 |
| MISSOULA COMPREHENSIVE DISTRICT | 1 | 2 | 6 | 9 |
| Kalispell Sub-District | 1 | 1 | - | 2 |
| Missoula Sub-District | - | - | - | - |
| Butte Sub-District | - | 1 | 6 | 7 |
| TOTALS | 4 | 11 | 38 | 53 |

TABLE 6.11

NUMBER OF COUNSELORS AND DEGREE OF QUALIFICATION
IN PUBLIC AND PAROCHIAL HIGH SCHOOLS
BY COMPREHENSIVE MENTAL HEALTH DISTRICTS AND SUB-DISTRICTS
1965

| ALL COUNSELORS IN SECONDARY SETTING | QUALIFICATION | | | | TOTAL COUN-SELORS |
|---|---|---|---|---|---|
| | NO SPECIAL TRAINING | 15 QUARTER HOURS | 30 QUARTER HOURS | UNKNOWN | |
| BILLINGS COMP. DISTRICT | 17 | 23 | 61 | 10 | 111 |
| Miles City Sub-Dist. | 7 | 6 | 12 | 2 | 27 |
| Billings Sub-District | 8 | 12 | 36 | 5 | 61 |
| Bozeman Sub-District | 2 | 5 | 13 | 3 | 23 |
| GREAT FALLS COMP. DIST. | 14 | 31 | 72 | 21 | 138 |
| Glasgow Sub-District | 5 | 9 | 18 | 2 | 34 |
| Great Falls Sub-Dist. | 9 | 20 | 45 | 16 | 90 |
| Helena Sub-District | - | 2 | 9 | 3 | 14 |
| MISSOULA COMP. DISTRICT | 13 | 15 | 37 | 13 | 78 |
| Kalispell Sub-District | 4 | 5 | 10 | - | 19 |
| Missoula Sub-District | 8 | 7 | 15 | 7 | 37 |
| Butte Sub-District | 1 | 3 | 12 | 6 | 22 |
| TOTALS | 44 | 69 | 170 | 44 | 327 |

The classroom teachers are the largest group in the professional component of the school system. A teacher's insight into human behavior and growth plus adequate school facilities gives the child an environment suitable for learning. The school then must provide opportunities for students to better understand themselves and their environment. This understanding can certainly be developed through the school function, and unquestionably plays an important role in supporting preventive mental health measures.

The importance of qualified teachers should not be underestimated, for the teacher is "more important than facilities or size of class in determining a student's classroom experience.".[1]

The degree of skill a teacher may possess in dealing with individual needs of students is difficult to assess. However, it is generally recognized that the teacher who has met the requirements for certification is better able than the non-certificated teacher to deal with pupil behavior problems. Even with the certificated teacher there is a "question about the degree to which present teacher training is oriented primarily toward the mechanics of teaching rather than toward an understanding of human behavior".[2] This statement is not meant to imply that the teacher should be an amateur psychiatrist. However, perceptive and sensitive teachers can effectively render psychiatric first aid to troubled children. There is no question that a teacher should refer a child who needs professional

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[1] Reginald Robinson, David F. DeMarche and Mildred K. Wagle, Community Resources in Mental Health, Monograph Series No. 5, Joint Commission on Mental Illness and Health, 1960), p. 158.

[2] Ibid, p. 158.

psychiatric evaluation or treatment; but the overburdened teacher simply does not have time to seek out appropriate resources that exist in the home community, much less seek out facilities in distant communities. It becomes acutely apparent from available statistics that a need exists in all school districts for professional help to supplement the teacher in assisting the child who has a mental or emotional problem.

## RECREATION

The importance of community recreation was stated by William C. Menninger in 1948: "An effective community recreation program is just as important to mental health as sanitation is to physical health".[1]

A county survey, conducted by the project staff through use of county committees, showed that many opportunities in recreation are available to the youth in Montana. All too often recreation was found to be interpreted as having particular reference to the youth of the community while the needs of the older population were not stressed.[2]

> "From the mental health point of view, the recreation problems of the aged is a dual one requiring a long-range plan (1) to help the aged to live more fully when retired, and (2) to prepare them to develop their resources to live a fuller life when they have more leisure" . . . .

This points out the need for the older individual to develop his skill in use of leisure time prior to retirement.

Little consideration was given for the recreational needs of the age group from 25-55. However, this age group needs the experience of

[1] Reginald Robinson, David F. DeMarche and Mildred K. Wagle, Community Resources in Mental Health, Monograph Series No. 5 (Joint Commission on Mental Illness and Health, 1960), p. 192.

[2] Ibid, p. 212.

informal association and creative activity as do older teenagers and young adults who had little organized recreational programming.

The county agricultural and home demonstration agents were frequently mentioned as having programs through 4-H clubs, home demonstration clubs, and community meetings. This study shows all but three counties in Montana have extension services. Frequent mention was made of demonstration clubs with mental health themes in their study programs.

Several community organizations sponsor recreational groups for handicapped children. A noticeable need exists in this sphere.

The family as a primary source of recreational activity was frequently stressed by several project committees. Clergymen particularly supported more and better community recreational activity, and often stressed its importance through such axioms as "families that play together stay together".

Several comments made during field studies indicated a lack of parental interest in giving time for group recreational activities. This inability to interest individuals in leading recreational groups was expressed by churches, PTA's and others.

A great many organizations have programs which lend support to home-centered activity. The incentive awards, in scouting and its divisions, offer opportunity for recreation and achievement much of which can be a function of the home and its environment. In many communities, parental apathy emerges as a severe deterrent to the establishment of successful recreational programs for youth.

Recreation is a vital and necessary program in the maintenance of good mental health in our communities. On-going programs designed to

assist all age levels in recreational activity should be initiated if active functioning groups do not already exist.

The importance of recreational opportunities for all members of the community was stressed by local committees. There was concern that organizations all too frequently overlook the individual who is a "loner". The "loner" is generally the individual most in need of successful group experience and more emphasis should be placed towards providing help to the person thus inclined.

## NURSING HOMES

Nursing homes were surveyed to determine their role in caring for emotionally-disturbed citizens of Montana. The information given in this section by homes surveyed was reported for March 31, 1964. A questionnaire was sent to 117 homes. Seventy-four replied to give a return of 63.25 percent.

In Montana, a home offering care to the recipient group under study may be licensed either as a hospital or as a home for the aged. However for the purposes of this study, no differentiation will be made with regard to the statistical data presented.

Of 74 homes reporting, 16 were operating over licensed bed capacity. The overload ranged from one to eight individuals. Twenty-two homes were operating at capacity. The 36 remaining were all operating at below licensed bed capacity and could have handled new patients ranging from one to 23 additional individuals. Generally speaking, the greater concentration of vacancies occurred in the populous counties in western Montana.

Of 2,021 total beds available in the reporting homes, 1,890 were occupied for a 93.5 percent occupancy. One hundred thirty-one beds, or 6.5 percent of the total available beds, were not occupied.

Table 6.12 indicates the 1964 cost per patient per month and the number of patients in each cost group for the reporting homes.

TABLE 6.12

COST OF PATIENT CARE
IN NURSING HOMES
MARCH 31, 1964

| PATIENT COST PER MONTH | NUMBER PATIENTS IN CATEGORY | PERCENTAGE IN EACH CATEGORY (10 20 30 40 50) |
|---|---|---|
| Less than $100 | 188 | 9.9% |
| $100 to $149 | 320 | 16.9% |
| $150 to $199 | 722 | 38.2% |
| $200 to $249 | 301 | 15.9% |
| $250 to $299 | 310 | 16.4% |
| Over $300 | 49 | 2.6% |
| Total Number of Patients in Study | 1890 | |

According to a census of Montana nursing homes taken by the Board of Health in 1960 and computations made on the basis of these findings, the median cost of patients per month in 1960 was $141.50 as opposed to the median cost of the 1964 sample of $180.00. The mean cost per patient in 1960 was $139.93 as opposed to our 1964 sample of $180.83. Although the 1964 sample was not as complete in its return as the 1960 survey, it is safe to assume on the basis of a 63.3 percent return that the cost per

patient per month has been rising since 1960. The increase in cost is approximated to be about 22 percent.

Table 6.13 shows a graphic breakdown of the general mental condition and numbers in each category of patients in reporting homes. Nearly 60 percent of the patients were reported as having symptoms of mental illness, being confused either part or all of the time. Patients reported as being "always clear" totaled about 40 percent.

TABLE 6.13

PATIENT MENTAL CONDITION
IN NURSING HOMES
MARCH 31, 1964

| PATIENT MENTAL CONDITION | NUMBER PATIENTS IN CATEGORY | PERCENTAGE IN EACH CATEGORY (10 20 30 40 50) |
|---|---|---|
| Always Clear | 762 | 40.3% |
| Confused Part of the Time | 697 | 36.9% |
| Confused All of the Time | 431 | 22.8% |
| Total Number of Patients in Study | 1890 | |

In a conference with the Director of Public Assistance on March 2, 1965, it was learned that the state will support an indigent patient in a nursing home by paying up to $120.00 per month of the cost of care. Prior to January 1964 this support was only $100.00 per month. The average cost of patient care was calculated to be $175.00 per month with a normal low of $125.00 per month and a normal high of $250.00 per month.

House Bill No. 19,[1] introduced in the 1965 Legislature, provides

[1] For a copy of House Bill No. 19, see Appendix C.

for utilizing federal grant monies appropriated under the Kerr-Mills Act for medical assistance to the aged. More needs to be done in developing programs for nursing homes for care of aged senile residents in their home communities. The Kerr-Mills program can be helpful in Montana in caring for our senile aged in their own communities.

## PUBLIC HEALTH NURSE

The public health nurse plays an important role in providing follow-up services to patients released from Montana State Hospital as well as working with patients referred by family physicians.

Public health nursing visits reported for mental health activity in years 1960-1963 show an upward trend in total visits made. Table 6.14 lists visits over the four-year period by first visits and revisits to mentally ill patients.

In January 1960, a mental health project, Family Health Services for the Mentally Ill, Project Number OM-421, was initiated by the State Board of Health. The Project's interim summary dated January 1960-December 1963 presents Project findings.[1] The Project is under the sponsorship of a National Institute of Mental Health grant which will terminate January 31, 1966. The visits are being made in the Butte-Anaconda area where the Project field office is located. In addition, public health nurses in 27 counties provide services to discharged mental health patients from Montana State Hospital. This Project demonstrates the effectiveness of the public health nurse in helping the patient and the patient's family in understanding mental illness. The public

[1] Montana, State Board of Health, Family Health Services for the Mentally Ill, Interim Summary (Helena, March 1964).

TABLE 6.14

NURSING VISITS
REPORTED FOR MENTAL HEALTH BY COUNTY
1960-1963

| COUNTY | 1960 | | 1961 | | 1962 | | 1963 | |
|---|---|---|---|---|---|---|---|---|
| | FIRST VISIT | RE-VISITS | FIRST VISIT | RE-VISITS | FIRST VISIT | RE-VISITS | FIRST VISIT | RE-VISITS |
| Beaverhead | - | - | 4 | 6 | - | - | 1 | 5 |
| Big Horn | - | - | - | - | - | - | 4 | 23 |
| Blaine | 1 | 4 | 8 | 37 | 3 | 23 | - | 6 |
| Cascade | 182 | 383 | 245 | 440 | 290 | 469 | 306 | 479 |
| Custer | 4 | 35 | 15 | 49 | 12 | 24 | 12 | 29 |
| Daweon | 9 | 19 | 11 | 16 | 5 | 23 | 5 | 16 |
| Fergue | 31 | 44 | 29 | 64 | 24 | 68 | 11 | 77 |
| Flathead | 20 | 31 | 21 | 29 | 12 | 28 | 4 | 9 |
| Gallatin | 45 | 169 | 42 | 149 | 36 | 268 | 29 | 128 |
| Glacier | 2 | 7 | 3 | 12 | 2 | 9 | - | - |
| Hill | 3 | 15 | 19 | 26 | 26 | 42 | 31 | 65 |
| Lewie & Clark | 16 | 49 | 41 | 113 | 24 | 36 | 21 | 37 |
| Lincoln | 56 | 9 | 64 | 8 | - | - | 24 | 3 |
| Mineral | - | 5 | 2 | 5 | 4 | 5 | 4 | 3 |
| Missoula | 27 | 27 | 60 | 90 | 67 | 131 | 125 | 266 |
| Musselshell | 10 | 2 | 15 | 7 | - | - | - | - |
| Park | 1 | - | - | - | - | - | - | - |
| Phillipe | 3 | 70 | 20 | 53 | 7 | 32 | 8 | 15 |
| Pondera | 11 | 17 | 7 | 30 | 14 | 60 | 9 | 20 |
| Ravalli | 17 | 39 | 35 | 105 | 24 | 47 | 15 | 87 |
| Richland | 23 | 94 | 81 | 67 | 31 | 94 | 24 | 113 |
| Rosebud | - | - | - | - | - | - | 2 | 3 |
| Sanders | - | - | - | - | 11 | 9 | 28 | 36 |
| Silver Bow | - | 3 | - | - | 2 | - | - | 1 |
| Teton | 7 | 21 | 8 | 22 | 14 | 73 | 15 | 76 |
| Toole | - | 9 | 6 | 4 | 8 | 52 | 3 | 19 |
| Valley | 10 | 11 | 7 | 31 | 2 | 13 | 3 | 10 |
| Wibaux | - | - | 1 | 7 | 2 | - | 1 | 4 |
| Yellowstone | 46 | 73 | 74 | 155 | 59 | 188 | 73 | 220 |
| Dietrict 1 * | 13 | 50 | 20 | 87 | 19 | 47 | 7 | 4 |
| District 2 * | 39 | 121 | 74 | 172 | 24 | 34 | - | - |
| Project Staff** | 26 | 97 | 60 | 700 | 62 | 815 | 112 | 1167 |
| TOTALS | 602 | 1404 | 972 | 2484 | 784 | 2590 | 877 | 2921 |
| TOTAL ANNUAL VISITS | 2006 | | 3456 | | 3374 | | 3798 | |

* These dietricte were composed of two counties each in a joint effort to provide eervices. Dietrict 1 includes Big Horn and Rosebud Counties. District 2 includes Lake and Sanders Countiee. District 2 was discontinued in 1962; Dietrict 1 was diecontinued July 1963.

** For an explanation of the "Project", refer to the third paragraph on the preceding page.

health nurses who worked in this demonstration project:[1]

> found there is no "magic" formula in attempting to identify differences in giving nursing services to the mentally ill as compared with other patients. The same public health nursing techniques used for other patients are utilized -- only the degree must be intensified.

The Public Health Nursing Division of the State Board of Health lists the following techniques as employed by public health nurses in the state:[2]

1. Accepts the patient as he is thus providing emotional support necessary to his ability to view himself as a person of worth.
2. Lets the patient know she is trying to understand the problems he faces and is making herself available to help solve his problems.
3. Provides a means for the patient to release his anxieties by carefully listening for what he is trying to communicate.
4. Accepts what the patient is communicating without criticism.
5. By setting some limits on erratic behavior and thought processes helps the patient to focus on reality.
6. Provides the patient with a person to trust by giving honest answers to his questions.
7. Is interested in the health of the patient both mental and physical and demonstrates this as she encourages him in those daily practices designed to improve his health. (Encouragement of the regular use of prescribed drugs is included here.)
8. Helps the family and community to accept the patient through her interpretation of mental illness to these groups.
9. Through her educational work with family and community can bring about change in those environmental factors thought to contribute to mental illness.
10. Can aid the physician in his management of the mentally ill patient by acting as a liaison to the physician, keeping him informed of the progress of the patient as she helps the patient to carry out the physician's plan for his care.

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[1] Ibid, p. 5.

[2] Letter from Mrs. Virginia Geiger Kenyon, Director, Public Health Nursing Division, State Board of Health, Helena, Montana, December 9, 1964.

All too often the mentally ill patient is set apart in care and treatment programs, but the "concerns of the mentally ill are not very different from those of other patients to whom the public health nurse gives service".[1] The information acquired through this Project will be furnished through the State Board of Health to all public health nurses in Montana.

Not all counties have public health nurses. Twenty-five counties have full-time nursing services, and eight counties have part-time services. This leaves 23 of Montana's counties (41 percent) without local service; however, to ascertain a factual presentation of service being rendered, population rather than counties must be the criterion. When thus considered, we find that 88.3 percent of Montana's population has either full or part-time nursing service. Map 6.2 shows public health nursing services in Montana as of January 1965.

Community education in all aspects of mental health needs is imperative if success is to be realized in promoting programs at the community level in prevention, treatment, and rehabilitation of the mentally ill. The existing programs of the State Board of Health in the Butte-Anaconda areas and the education project in the Kalispell area are examples of what can be done.[2]

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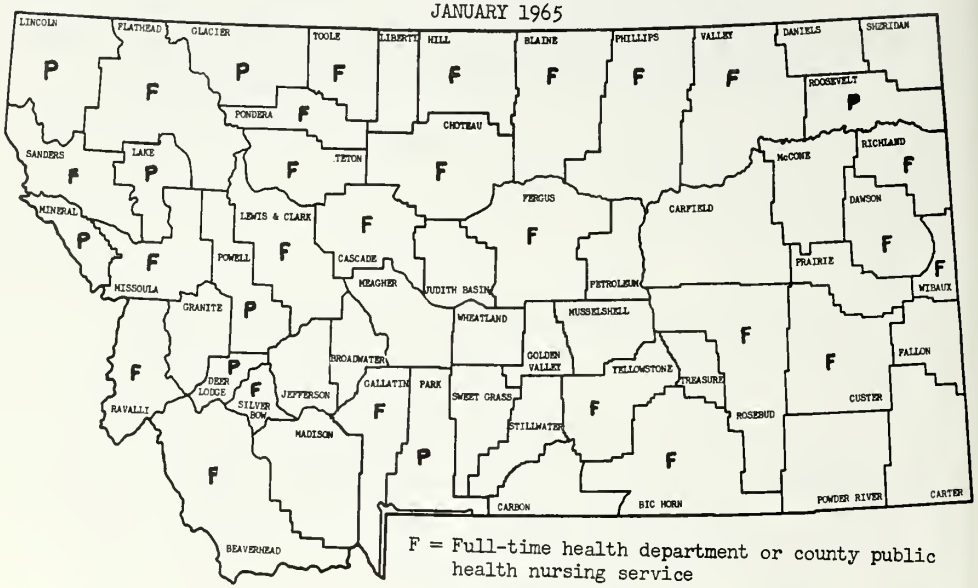
[1] Montana, State Board of Health, Family Services for the Mentally Ill, Interim Summary (Helena, March 1964), p. 5.

[2] For a further discussion of community mental health education, see Elaine Cumming & John Cumming, Closed Ranks: An Experiment in Mental Health Education (Cambridge, Massachusetts: The Commonwealth Fund by Harvard University Press, 1957). This writing is perhaps the most thorough evaluation of mental health education program yet achieved.

MAP 6.2

PUBLIC HEALTH NURSING SERVICE
IN MONTANA
JANUARY 1965




F = Full-time health department or county public health nursing service

P = Part-time nursing service, county or school

Nurses hired in local counties are employed by Board of County Commissioners or by school board, not only to function in the prevention of disease and disability, but also for promotion and maintenance of health. Medical participation and direction are implicit components of therapeutic and preventive nursing service for individuals and their families. Of primary importance in the treatment and care of the mental patient is the attitude of the community towards rehabilitation assistance. Public health nurses can function effectively as liaison people in developing community attitude.

Since 1960, graduates of the Baccalaureate Nursing Program at Montana State College have been prepared for beginning positions in public health nursing through their academic program.

Local health departments have taught classes on mental health problems to high school students and other groups. This type of educational activity is indicative of the way school and health departments are cooperating in Montana to better educate our youth in mental health.

The public health nurse can serve in a variety of important ways. She can function in case identification, health guidance, interpretation of the home environment of the patient and in family counseling. She can also serve as liaison between the Board of Health and the community. Much more can be done to develop this valuable professional resource - the public health nurse.

## MONTANA ASSOCIATION FOR MENTAL HEALTH

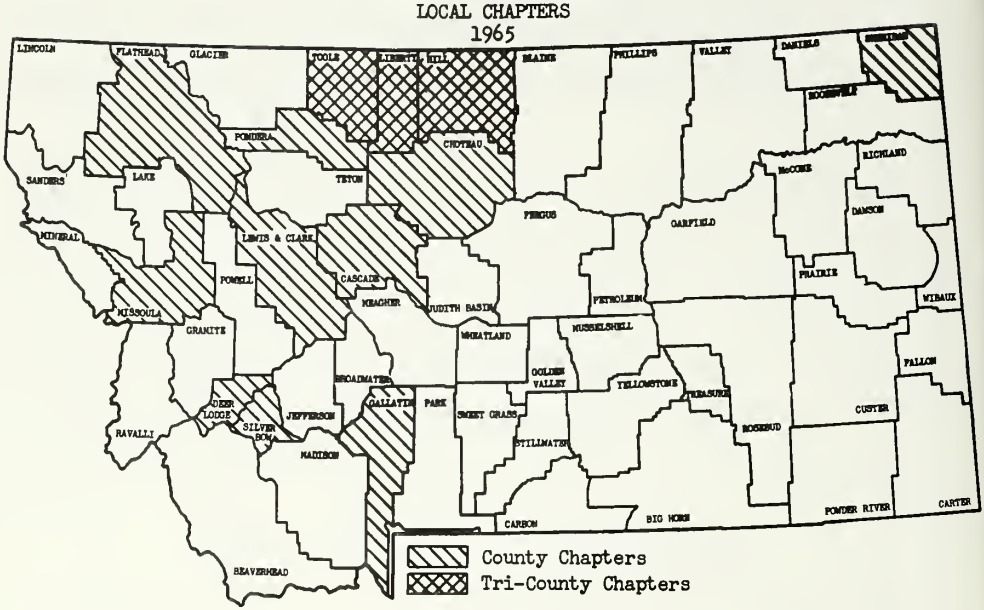
Montana Association for Mental Health is entering its fourth year as a division of the National Association for Mental Health. In 1950, the Montana Association began on a small but state-wide basis known then as the Montana Society for Mental Health.

The structure of the present Montana Association for Mental Health consists of a 21-member Board of Directors. The board members are distributed throughout the state. An Executive Director was employed for the first time on November 1, 1961.

Local chapters of the Montana Association for Mental Health are shown on Map 6.3.

MAP 6.3

MONTANA ASSOCIATION FOR MENTAL HEALTH
LOCAL CHAPTERS
1965




The Montana Association for Mental Health is especially interested in:

1. Improved care and treatment of the hospitalized mental patient.
2. Services and facilities for after-care and rehabilitation.
3. Treatment, schooling, and special services for mentally ill children.
4. Community based mental health facilities and services.[1]

The "Bell Ringer Campaign" is conducted each year as a fund raising campaign for the Montana Association for Mental Health. In 1964,

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[1]Letter from Mrs. Walter Needham, Executive Director, Montana Association for Mental Health, Anaconda, Montana, February 11, 1965.

$14,194.46 was reported collected as of December 1964. The production of the 1964 "Bell Ringer Campaign" was 49.1 percent of the suggested goal of $28,910.00. The activity of the MAMH is curtailed by the shortage of funds.

The Association promotes an annual conference for local religious leaders, doctors, teachers and others which helps promote better mental health services in Montana.

Recognition of the need for a strong mental health association is important if the public is to become actively involved in a program for better services. In his book, A Mind That Found Itself,[1] Clifford Beers speaks of a vast program of public involvement in the fight for better mental health practices. This concept has never been brought to full fruition. Many states are still struggling to develop NAMH chapters. Montana has yet to establish mental health chapters on a state-wide basis. The "Bell Ringer Campaign" lags in all but a very few areas.

Under the program envisioned by Beers, services would be offered to the patient; scientific research would be conducted; and provision would be made for dissemination of educational information to the public and to professional media. Much of this has not been fully realized. Montana is still on the doorstep in the development of such a program.

## ALCOHOLICS ANONYMOUS

Alcoholism is and in all probability will continue to be a very serious and complex problem. Society by its very nature breeds, but at

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[1] Clifford Whittingham Beers, A Mind That Found Itself (New York: Doubleday, 1921). Mr. Beers (1876-1943) was secretary of the National Committee for Mental Hygiene until his death.

the same time, rejects the alcoholic. One unfortunate enough to become so habituated to alcohol that his body and mind is diseased to the point of addiction can expect little, if any, empathetic support from the community that helped produce him. The mores of our advanced society applaud alcohol imbibition as a means to "win friends and influence people", and yet this same society appears horrified in hypocritical disgust when one of their number has degradated to the status of "drunk" or "sot", or to the perhaps more dignified, but equally disreputable, "alcoholic".

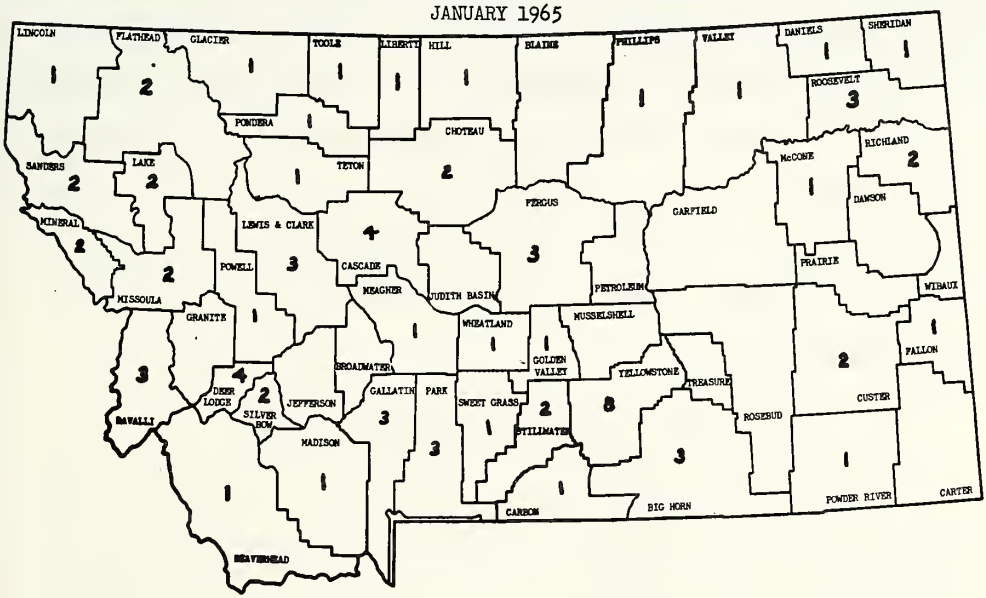
The community must become aware of and support its local resources which can provide assistance to the alcoholic. One of the best known programs in alcoholic rehabilitation is Alcoholics Anonymous (AA).

Alcoholics Anonymous is a special program designed to assist the recovering alcoholic to rehabilitate himself and offer him fellowship of others with like problems. The state organization of AA is the Montana Allied Alcoholics Anonymous group which is a loose alliance of autonomous AA groups in the state. Representatives from the groups throughout the state meet regularly in semi-annual conference to exchange ideas and facilitate inter-group activity. Every two years an experienced member is selected to be the Allied groups' delegate to the annual General Service Conference of Alcoholics Anonymous held in New York City. This selected delegate also serves as state chairman and is assisted by a vice-chairman and a state secretary. All past delegates serve as an advisory board. Special committees are appointed by the state chairman to guide Montana AA public relations policy, to facilitate cooperation with other agencies working with the alcoholic, and to assist in the organization of AA groups in various public institutions in Montana.

The first AA group was organized in Montana in 1946 with two members. The latest available information lists 51 registered groups and 18 "loners" with a total membership of more than 700. AA groups are active in six institutions within the state. Map 6.4 indicates the coverage in Montana counties by the AA group.

MAP 6.4

COUNTIES SERVED BY
ALCOHOLICS ANONYMOUS GROUPS OR LONERS
JANUARY 1965




Each local AA group is autonomous and carries out such activity as it sees fit within the limits of broad policy as outlined in the 12 traditions which guide the fellowship. No one individual nor group of AA members may represent or speak for AA. However, individuals or committees of AA members may and do cooperate with other agencies interested in alcoholism.

Community contacts revealed that the clergy, doctors, social welfare and law agencies consider AA a useful resource for help to the alcoholic. Close cooperation exists between AA programming and the Montana Alcoholism Services Center at Warm Springs. Continued demonstration that the alcoholic can be reclaimed as a useful and respected member of the community has been an important factor in educating the public to the AA program. The stigma attached to alcoholism is still prevalent, and in all probability, has kept some from joining AA groups. The AA "public relations policy is based on attraction rather than promotion; we need always maintain personal anonymity at the level of press, radio and films".[1] Alcoholics Anonymous by its nature does not solicit membership; rather the alcoholic must solicit the aid of the organization because he has the desire to be helped. Because of this absence of promotion, community support is vital and necessary to a strong productive AA program.

## MONTANA COUNCIL ON ALCOHOLISM, INC.

This voluntary council on alcoholism was incorporated under the non-profit laws of the State of Montana in 1961, and is affiliated with the National Council on Alcoholism. Its officers and a 50 member Board of Directors are representative of agencies, professions, disciplines and industry that are concerned with alcoholism.

The State Council has 10 local affiliates which carry out varying programs of public information and education on alcoholism, operate

[1] Alcoholics Anonymous, Twelve Steps and Twelve Traditions (General Service Headquarters: Alcoholics Anonymous World Service, Inc., 1960), p. 184.

information and referral centers, and work towards development of treatment, rehabilitation and prevention resources at both the state and local level.[1]

The most outstanding accomplishment of the Montana Council on Alcoholism since its inception was to persuade the 1963 Legislative Assembly to repeal the old 1911 State Hospital for Inebriates Act and create the present Montana Alcoholism Services Center as the official state agency in the field of alcoholism.

The Montana Council on Alcoholism maintains close liaison with the Montana Alcoholism Services Center and the Montana Allied AA groups, and cooperates extensively with these agencies.

## MONTANA ALCOHOLISM SERVICES CENTER

The Montana Alcoholism Services Center is the official state agency on alcoholism located at Warm Springs, Montana. It was created in the 1963 legislative session by House Bill No. 54. It is a separate, legislatively created department of Montana State Hospital established to provide the following special services in the field of alcoholism:

1. Treatment and rehabilitation of alcoholics.
2. Provide consultation and cooperation to Montana communities.
3. Provide public information and education on alcoholism.
4. Initiate, encourage, and coordinate alcoholism research.
5. Cooperate with other agencies to further the work of the center.

It has at its head a coordinator of the Alcoholism Services Center who is directly responsible to the Superintendent of Montana State Hospital.

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[1] See Appendix D.

LAW AGENCIES

Many jails in Montana and throughout the nation are being used to detain the mentally ill prior to adjudication of their cases. It has been the opinion of law officers and certainly of mental health authorities that this practice is outmoded, inequitable and most definitely not in the interest of the mentally ill individual. It should be the responsibility of local hospitals to offer detention services to the mentally disturbed person. Montana Licensing Law and Standards For Hospitals and Related Institutions stipulates that a mental unit shall be provided by any "generalized hospital" that is categorized as either a "general hospital" (100 beds or more), an "intermediate general hospital" (40-99 beds), or a "small general hospital" (10-39 beds). The actual provision within the law reads:[1]

> A mental unit shall be provided in a section which can be separated from other patients. For existing facilities, if this cannot be provided, there shall at least be facilities for the temporary handling of mental patients in the community either through this hospital or a second hospital in the community. The isolation facility and mental unit facility may be used interchangeably. Alcoholics and temporarily disturbed patients are included in this category.

Although the law specifically states that these mental units shall be provided, it is known that most hospitals, although required to do so by law, are not fully providing this service.

It is strongly recommended by the Planning Committee that "generalized" hospitals be encouraged to have this type of facility available for use.

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[1]Montana State Board of Health, Montana Licensing Law and Standards for Hospitals and Related Institutions, Amended to July 1, 1963, Section H, Sub-Section A., 1., g.

It is believed that law enforcement officers would welcome the opportunity to share the responsibility of this type of person with local hospitals. Since the county jail has become a type of detention area for the mentally ill, sheriffs' offices are instrumental in the custodialship of these persons. The National Sheriffs' Association is in accord with the view that the hospital is the place for restraint of the mentally ill. Their national publication:[1]

> The National Sheriff (1956) carried a copy of the resolution "urging abolishment of the county jail as a temporary detention facility for the mentally ill". It is reported that this resolution represents the almost unanimous view of the county sheriffs.

In the survey conducted by the local Planning Committee groups, it was noted that police and sheriffs' offices expressed dissatisfaction with the necessity of detaining the mentally ill in the county jails.

## DELINQUENCIES

The number of children seen in Montana's juvenile courts cannot be clearly defined. Some courts would not release information regarding juvenile problems and others were very reluctant to do so. Both judges and probation officers indicated a need for psychiatric evaluation during the pre-sentencing examinations of both juvenile and adult offenders. The majority of the reported juvenile cases were housed in the jail and all too frequently, proper segregation could not be maintained from adult prisoners. It is recognized that it is desirable to even segregate among juveniles of the same age. One probation officer dealing largely with

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[1] Reginald Robinson; David F. DeMarche; Mildred K. Wagle: Community Resources in Mental Health, (New York: Basic Books, Inc., 1960), p. 304.

Indian youth wrote:

> That institutional and/or categorical placement of juvenile offenders is so lacking in this state that many Indian juvenile offenders are placed in the one correctional facility for boys when they should have been placed in forestry-youth camps or other arrangements whereby they could benefit from modern juvenile rehabilitation programs.

This same reasoning of course extends to other youth throughout the state.

Juvenile probation counselors are helping a great number of youngsters in their community to make a better social adjustment. However, all reporting public agencies having to do with juvenile problems expressed the need for more adequate psychiatric consultation.

## THE GOVERNOR'S JOINT COMMITTEE ON MENTAL HEALTH AND MENTAL RETARDATION

This Committee was organized in May 1962 as an advisory body to assist the Governor in a program of improved mental health services. Seventeen interested persons were selected by the Governor to serve on the Committee. The Committee has functioned since that time in this capacity and have submitted a report of their activities to the Governor in the form of a 27 page document. This Committee should be recognized as an important supportive resource.

## MENTAL RETARDATION PLANNING PROJECT

This project began operation in Montana on July 1, 1964. Similar to the Mental Health Project, it is a federally financed program having received $30,000.00 for its study which is to be conducted from July 1, 1964 to December 31, 1965. It has two members on its full-time staff,

a coordinator and a secretary. There are 56 members on its Planning Committee from which was selected a four person Steering Committee. They have constituted five sub-committees to study special problems. This Project is conducting a county-by-county survey of mental retardation incidence and available resources; upon this data will be based a subsequent determination of needs. The Project visualizes as one of its most important functions, a planned program of public education and information. Upon completion of the Project on December 31, 1965, a comprehensive plan will be formulated, written and submitted.

## CHAPTER VII

## MANPOWER

MAN - human being. POWER - ability to act; capacity for action; capability of producing.

As indicated in the definition of the word used in this chapter, the Planning Committee is concerned with men and women who are available for mental health activities. Their numbers are important, but, of even greater consequence, is the power they possess to help, support, relieve, remedy and prevent mental and emotional illness among the people of the state of Montana.

### PSYCHIATRISTS

In the past, as in the present, a number of professional and lay people have concerned themselves with the care and treatment of the mentally ill. Of these, the physician, especially the psychiatrist, has been placed in the position of leadership to give guidance and direction to the others. The supply of psychiatrists in the nation is increasing but the demand still far exceeds the supply. Fifteen years ago in Montana, except through the State Hospital or the mental hygiene clinics, only one or two psychiatrists were available to the citizens of the state Today, in addition to all of the physicians who practice medicine generally, there are 26 physicians who devote their full time to the practice of psychiatry; ten are employed in the State Hospital, and the balance are in the community setting either in private practice or in state mental hygiene clinics. Six psychiatrists are located in Billings, four in Great Falls, two in Missoula, one in Kalispell, one in Miles City,

one in Bozeman, and one in Helena. Many of these physicians have met the requirements for board certification in the specialty of psychiatry and neurology; others are eligible for board certification but have not yet taken their tests.

It is generally agreed that board certification is desirable for physicians who wish to spend full-time in the practice of psychiatry. This insures that the physician has had a number of years, beyond graduation from medical school, of training and experience in dealing with mental and emotional problems; thus, if training and experience are of any value, this should increase the physician's power to assist those who have emotional and mental problems. Physicians who have specialized in other areas, such as ophthalmology, surgery, radiology, etc., do not ordinarily deal with individuals suffering from mental and emotional illness except as it may relate to the specialized condition for which they are treating patients. The general practitioner and, in many instances, the internist often spend a good deal of time in treating the whole patient and are concerned about his total condition. It has been said that the general practitioner is the bulwark of medical help to the mentally ill in the nation at this time.

In the past the specialty of psychiatry was relatively narrow in its implications because of an over-emphasis upon organic causation at the end of the nineteenth century. However, in the past 50 years, with the increased recognition of psychological causation of mental disorders and a possible remedy by psychological means, the field has become attractive to more physicians. Diseases which include both psychological

and organic disturbance have been better studied and the status of this branch of medicine has increased. Rather than treating mental disorders in isolated settings, there is a healthy trend toward treatment in community clinics and general hospitals, and on a purely private basis. Because of the time-consuming nature of individual psychotherapy, purely private care has often only been within the means of a relatively small portion of the population. However, state or federally supported services are now being provided to a larger portion of the population at relatively minimal cost to the patient. As the medical director of the American Psychiatric Association, Walter E. Barton, remarked in the introduction to the book, THE COMMUNITY MENTAL HEALTH CENTER: "The psychiatric disorders of the blue collar worker and the medically indigent are the hardcore problem".[1] Facing the challenge of the disorders that are filling half the hospital beds in this county, many dedicated and highly qualified physicians are now deriving much satisfaction from practicing, at least a portion of their time, in programs designed to coordinate health agencies, effect preventative measures, emphasize social and family factors in these illnesses, etc., even though the remuneration may be somewhat less than the physician doing a purely private practice.

The physician now graduating from medical school has a much greater foundation and background in the treatment of mental and emotional illness than the physician who graduated 30 years ago. Modern medical

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[1] Raymond M. Glasscotte, David S. Sanders, H. M. Forstenzer, A. R. Foley, The Community Mental Health Center, An Analysis of Existing Models (Washington, D.C.: The Joint Information Service of The APA, et.al., September 1964), Intro. XVI.

schools start at the beginning of the curriculum to keep the physician informed and aware of the importance of the psychological state of the individual as it relates to his general health. Of necessity, the psychiatrist has to establish his practice in large metropolitan centers and usually can make his services available to people in the rural communities only when they can transport themselves to his office in the city. The number of psychiatrists successfully practicing in the state of Montana, serves as an inducement to encourage more psychiatrists to begin practice. It is expected that the number of psychiatrists in the state will continue to rise; however, it is not expected that this rate will be dramatic due to many factors, discussed later in this chapter, that negate against this increase.

## PSYCHOLOGISTS

Another professional group traditionally associated with the care and treatment of the mentally and emotionally ill is that of the psychologist. At the present time, there is no complete enumeration of the psychologists in the state of Montana. The state has no regulations which would require working psychologists to register with a central agency. Partial listings exist in the directories of the American Psychological Association, the Montana State Psychological Association, the Montana State Merit System, and the National Register of Scientific and Technical Personnel. The state and national organizations, however, are limited in membership and the Merit System covers only a small number of employees in the state. A number of psychologists in Montana are not included in the above mentioned groups, but it has been impossible to

determine the exact number. It should be noted that presently the Montana Psychological Association has developed a self certification program under which has been established an Examining Board that soon will be publishing a list of "certified" member psychologists. In addition, there are several psychologists now working in Montana who hold certification in other states.

The 1963 Directory of the American Psychological Association lists as being members and associate members 26 psychologists who are residents of Montana. Of this group, over half (16) have their Ph.D. or Ed.D. degrees. All others have Master's degrees. Five of the psychologists earned their degrees in Montana educational institutions. In four cases, it was the M.A., and in one the B.A. which was earned at the Montana school. Not one psychologist among the group earned the Ph.D. in Montana. The three persons with the longest records of service in the state earned the M.A. degree at Montana educational institutions; the three above-mentioned individuals and one other have well over 15 years of service in the state. About half of the remaining group have worked in the state between 10 and 15 years. A third of the group have five years or less service in the state.

With reference to age, the psychologists considered here are a mellowing group. The youngest is 35. Four others are in the 35 to 40 year age bracket; six are between 40 and 50; and the others are over 50. A few females are evidently ageless since they list no date of birth. It is presumed, however, that these women fall in the category above 50 on the basis of the dates on which their degrees were awarded.

Some comparisons between neighboring states are of interest. If mere numbers count, Montana is more abundantly supplied than the neighboring state of Idaho where, with a state population approximately the same as Montana, there are eight fewer psychologists. Both Wyoming and Nevada, however, with approximately half the total population of Montana, equal the number of psychologists; Utah, with only slightly more population than Montana, has almost quadruple the number of psychologists; Colorado, with about twice the population, has 10 times the number of psychologists.[1]

These data show clearly that manpower in the field of psychology is concentrated strongly near universities and colleges. Sixty-nine of the 100 psychologists in Utah are associated with the three educational centers; of the 28 psychologists in Wyoming, exactly one-half are associated with the university and Sheridan College; the same trend is strongly prevalent in the other states.

Surveys of communities in the various counties and districts of Montana indicate that people generally are not aware of the number of psychologists available to treat the mentally ill and emotionally disturbed in the state. As indicated above, the concentration of psychologists is in the university centers; this indicated that possibly most of the psychologists' time is spent in teaching and training students, probably at the undergraduate level. To date, no Ph.D.'s in psychology have been awarded in the state of Montana; students have gone out of

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[1] American Psychologist Association Directory, (Washington, D.C., 1963, American Psychologist Association Inc.), pp. 916-1064.

the state for their Ph.D. degree training. At the present time, a Ph.D. in psychology is considered prerequisite to effective clinical practice in the treatment of mental and emotional illness. The fact that psychologists take their training in other states is presumably a reason why Montana lacks younger psychologists, since they leave Montana to complete their training, and are offered employment in other areas, they do not return to the state following training.

It has been announced recently that a Ph.D. training program in experimental and clinical psychology has been started at Montana State University in Missoula. It usually takes three to five years to complete all of the work required for a doctor's degree in psychology, a minimum of three years in experimental and at least four to five years in clinical psychology, and it is expected that the number of students will be small at least in the early years of the program. The addition of this Ph.D. program to Montana's university curriculum will, however, eventually be a significant factor in supplying psychologists to Montana's future mental health programs.

At present, there are no psychologists practicing in Montana in a strictly full-time private practice available to the general public; however, there is some part-time private practice being conducted on a limited basis in Montana. The small number of psychologists in private practice are associated with psychiatrists or other medical personnel. The fact that the psychologists with longest tenure in the state had their training in Montana institutions seems to indicate that home training would be of some value in retaining psychologists in the state.

As in the case of psychiatrists, success begets success, and the fact that the psychologist has not established himself very firmly in the state of Montana, magnified the problem of attracting other psychologists into professional association with those already here.

This is especially true in terms of training. In order to train clinical psychologists, strong diagnostic and treatment centers must be available to which students can be sent for full and complete training. Traditionally, this has been done in the mental hospitals. Since Montana State Hospital at the present time has no Ph.D. psychologists, it is very difficult, if not impossible, to institute the proper training which would include the experience necessary to qualify a psychologist for service in this field. Since most psychologists are associated with the university system, this appears to be the best setting from which to augment and enlarge the psychological staff. In time, perhaps the staff members could be made available to other agencies, and thus serve as training nuclei for future psychologists for the state of Montana.

## SOCIAL WORKERS

For many years, especially in outpatient clinic work, the services of psychiatric social workers have been included with those of clinical psychologists and psychiatrists in treatment of mentally and emotionally ill through a "team approach". The social worker, by reason of training, has been able to emphasize important aspects of social, family, and economic problems bearing on the total picture affecting patients. In the beginning there was a tendency toward rigidity in the physician's

approach to individual symptomatology, in the psychologist's approach to the individual by psychological testing, and in the social worker's emphasis upon family, social and economic factors. However, a trend toward psycho-social orientation of all three professions is now evident. All three now actively participate in treatment. Since the treatment of the mentally and emotionally ill is primarily a medical responsibility, the psychiatrist must have the authority and final responsibility for the clinic team. Several centers are now giving special instruction in community psychiatry. Clinical psychologists are giving much more attention to family and social factors, as well as purely individual psychology, and social workers are being more fully utilized in coordinating allied professional groups at the community level.

In the state of Montana, at the present time there are 60 social workers who have graduated from approved schools of social work. Of these, approximately eight deal directly with the mentally and emotionally ill in psychiatric or medical settings. The rest of the trained social workers are scattered throughout the state and are performing a number of functions including child welfare services, adoptive placement, family services, public assistance, administrative responsibilities, etc. As in the case of the psychiatrist, there are no training facilities in Montana for the advanced degrees recommended for full training in the field of social work. Of necessity, all social workers in Montana who have been trained in approved schools of social work have received their training elsewhere. Three social workers were trained under stipends sponsored by Montana State Hospital, a substantial number have been sponsored by the Department of Public Welfare, and others have received

their training through stipends from agencies in other states or from personal funds.

The Montana Department of Public Welfare has had an extensive educational leave program designed to recruit and train professional social workers. This program began in March 1937. In the early years, money was made available to a very limited group because of shortage of funds. Beginning about 1951, more funds became available and the Department was able to arrange for educational leave allowance for anyone who was interested in and could gain entrance to an approved school of social work. The total number educated under this program since its inception, including the few in school now, is 98. Of this number, 48 persons are still members of the staff of the Department. Fifty people separated from the Department through the process of resignation: 19 because of marriage, 30 for other jobs (some within the state and some without), and one deceased. One of the provisions of this educational leave program is a requirement that the recipient be committed to $1\frac{1}{2}$ years of service to the state of Montana for each year of schooling. In only two instances did employees leave prior to the expiration of their commitment in Montana; the balance, or 96 people, remained beyond the time of their commitment - some of them for many years and others, a matter of months. Since practically all of the social workers in the state of Montana are employed by either state, local or private agencies, they deal principally with people who are economically deprived and cannot avail themselves of services elsewhere. As indicated previously, the psychiatrists, except those employed by the state, are dealing with

the upper classes; the social workers, principally with the lower economic groups.

In addition to the number of professionally trained individuals, there are, throughout the Department of Public Welfare, a number of social workers with varying degrees of training and experience who work with the general public assistance field. Many of the assistance problems are of an economic nature. Most of them, however, have strong emotional and psychological components.

Fifteen years ago there were approximately 20 fully trained social workers in the state of Montana; at present, there are approximately 60. This shows considerable growth in the number of social workers being employed in the state, and, as in the case of psychiatry, success brings success.

For a number of years, at Montana State University, there has been a strong social welfare program calculated to develop the abilities of students at the undergraduate level, who have interest in social welfare problems. Most of the recruits for the field of social work and for many welfare positions have come from students who have taken this undergraduate training program. This indicates that training early in an individual's college life may steer his interest into the helping professions, such as social work.

The Western Interstate Commission for Higher Education summer work study program in mental health offers to selected college students the opportunity to spend 10 weeks in gaining both academic and practical experience in the field of mental health. Montana will be participating in this year's summer work study program for the first time, and it is

anticipated that 10 college students will be a part of the 1965 program in Montana.

As in the fields of psychiatry and psychology, demand for social workers far exceeds the supply. Every student graduated from a graduate school of social work usually has numerous jobs to choose from if not under a commitment to return to the agency sponsoring his graduate school training. It would appear that the stipend, or educational leave with financial assistance program, has been the greatest help in recruiting social workers to the state of Montana. In order to be successful, however, these educational leave programs must provide benefits commensurate with educational leave programs sponsored by other states. For example, Montana requires a year and a half of work commitment for every year of training, while many other states require only one year of commitment for one year of training. This, at times, tends to build up negative forces within individuals on the educational leave program, and creates ill feeling toward the state of Montana. When the training has been completed with a job under a stipend program, working conditions and salary should be at least equal to those in neighboring states. Montana people have a greater tendency to remain in the state provided they can receive financial remuneration commensurate with that available in the surrounding states. At the present time, a number of stipends are not being used because of lack of interest and, as indicated, most of these stipend training programs are designed to recruit social workers for the general field of social work rather than particularly in the field of mental health. There is not now an active stipend in the field of mental health, and, if the experience of the Department of Public

Welfare is indicative, a real potential for recruitment in the state for social workers exists here.

Another important factor in the recruitment of mental health personnel is the type of program offered the citizens of the concerned communities. Most professional people working the field of mental health are extremely dedicated and interested in providing the best quality of service to clients. Unless the program of the state or the community is forward-looking and progressive, mental health personnel will seek a more gratifying environment for their efforts.

The importance of a forward-looking and progressive program in recruiting and holding staff is expressed in the following statement of City Hospital, a psychiatric inpatient facility in the city of New York.[1]

> Our experience in enlisting the services of an adequate number of qualified personnel has been quite atypical. Customarily, although the budget of a municipal institution such as City Hospital makes fairly ample provision for the requisite number of staff personnel, the institution itself is subsequently unable to secure such professional services at the salaries provided. Conversely, at City Hospital we have been able to fill all the positions which we were allocated "on paper". As a result, our full-time staff presently consists of 12 psychiatrists, 15 residents, 10 psychologists, a recreational therapist, and 10 full-time social workers, whose services are supplemented by 9 social work students in field placement. Furthermore, we have been able to enlist the additional services of a sizeable part-time staff. In many instances, these staff members are part of the unpaid attending staff; others are compensated for their services on an hourly basis.

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[1] Leopold Bellak, M.D., Handbook of Community Psychiatry and Community Mental Health, (New York: Grune and Stratton, Inc., 1964), pp. 149-150.

> For some reason, the salaries paid by the City are lower than those paid by any of the comparable institutions - including the Veterans Administration, State Hospitals, etc. If we were able to acquire a full staff nevertheless, it is due to the fact that a lively program, which demands work of a quality which is consistent with self-respect, will attract capable personnel, even in the presence of low salaries. Undoubtedly, our ability to attract and keep our staff may also be attributed to our adherence to the team concept. Psychologists and social workers are not considered minions of the physician, but his fellow workers on the team. Central to the team concept is the fact that each member has a special skill to offer and that skill constitutes his first line of service. After the social worker has contributed the necessary share of casework, and the psychologist his share of testing and research skill, the psychiatrist his special medical skill, they all share in the therapeutic task, according to their individual capacity.

## NURSES

Psychiatry, psychology, social work and nursing are considered the four core disciplines in the care and treatment of the mentally and emotionally ill.

In 1953, the Coordinating Council of the American Nurses Association and the National League for Nursing developed a series of statements with reference to psychiatric nursing care:

(1) Psychiatric nursing is first an aspect of all nursing, and also a specialized field of practice.

(2) All who give nursing care to psychiatric patients are nursing personnel. This includes registered nurses, licensed practical nurses, attendants or aides.

While psychiatric nursing has been recognized as one of the major clinical nursing areas for only the past 25 years, it is shocking to see statistics which point out that only five percent of the professional nurses employed by hospitals are working in the area of psychiatric nursing, when concurrently 50 percent or more of all hospital beds are occupied by patients with mental disorders. While professionals in all disciplines are in short supply, psychiatric nurses are the most acutely needed.

Nurses themselves share a major responsibility for this shortage. In the past and to some extent now, the image of the nurse who devoted her talents to the care of the psychiatric patient was not an image that encouraged other nurses to enter the field of psychiatric nursing.

Too often traditional patterns of nursing service from general hospitals have been transplanted to psychiatric hospitals. These patterns of nursing service do not provide opportunity for nursing personnel to function with individual patients or groups of patients in a psychotherapeutic setting. Administrators, as well as nurses, frequently resist change in patterns used in general hospitals. Patterns which provide creativity, initiative and willingness to experiment may well help define a role for nursing which will increase the effectiveness of the nursing care and encourage more to enter this field of nursing. The role the nurse can assume in the care of the mentally ill is, and has always been, dependent upon the progress in the development of psychiatry.

Because all who give nursing care are considered nursing personnel, some identification of the various levels of educational attainment seems indicated.

(1) A psychiatric or mental health nurse is a registered nurse who has completed all of her professional education and has had from one to two years of graduate study in psychiatric nursing in an accredited university program and holds a Masters degree.

(2) A staff nurse is a registered nurse who has completed some portion or all of her professional education. She may be a graduate of a three-year diploma school, two-year associate degree, or a collegiate school of nursing. A nurse graduating from a collegiate program holds a bachelors degree and has full preparation for staff nursing in any institution. Since 1950 all graduates of schools of nursing in Montana have had an affiliation at Montana State Hospital.

(3) A licensed practical nurse is a nurse who has completed a one-year program in an accredited school for practical nursing and has passed the examination for licensure.

(4) Attendants or aides are persons who may or may not have had experience in giving nursing care. The training for this category of workers is obtained through in-service educational programs supplied by the agency or institution employing them.

Information obtained from the Montana State Board of Nursing and the Department of Nursing at Montana State College reveals some rather interesting statistics about nursing "manpower". Of the 4,580 nurses licensed in Montana for the year 1963, 2,418 were employed in hospitals, physicians' offices and nursing homes, as well as in educational programs

and public health. An unknown number engage in private duty nursing. Of the number of nurses employed by hospitals, less than two percent are giving care to psychiatric patients.

Schools of nursing in Montana graduated 163 nurses in 1963; of this number, 34 hold bachelors degrees. This indicates that the greatest potential source of nurses is from diploma nursing schools.

In Montana, 11 nurses have some advanced formal preparation in psychiatric nursing and two have Masters degrees in public health with a major in mental health. Of the 11, one is employed at Montana State Hospital, and 10 are employed on the teaching staff at Montana State College.

During the last 15 years, tremendous progress has been made in the quality of graduate study in psychiatric nursing. Despite this fact and the fact that financial assistance is available for graduate study, recruits are lacking. Of those who do take graduate work, few find it agreeable to work in the frustrating conditions of state hospitals.

## STATUS OF NURSING MANPOWER AT MONTANA STATE HOSPITAL

According to the American Psychiatric Association Standards, Montana State Hospital has been able to recruit only 10 percent of the required number of graduate nurses. It is encouraging, however, to note that one-third of the nurses employed hold bachelors degrees and one holds a Masters degree. The rate of turn-over for graduate nurses is 63 percent.

Approximately 50 percent of the required number of practical nurses are employed at Montana State Hospital and the rate of turn-over is 28 percent.

In the attendant category, the Hospital fares somewhat better. Seventy-six percent (76%) of the estimated number are employed, but the rate of turn-over averages 55 percent. Since the majority of these people have had no previous experience in caring for psychiatric patients, the burden of training these people is tremendous. On July 1, 1964, Montana State Hospital received a federal grant to develop a training program for the attendant staff. This training program should help stabilize the attendant staff and contribute to better patient care.

## PUBLIC HEALTH NURSES --- A COMMUNITY RESOURCE

Public health nurses are another source of manpower to help meet the needs of the mentally ill. The idea that a public health nurse can work with the mentally ill is not new, as she has already been serving in this capacity as a part of her generalized services to families. In routine services to families the public health nurse is in a unique position through direct contact and relationship with families in times of stress. The public health nurse thus has the opportunity to observe behavioral deviations exhibited by various members of the family and to serve as a referral agent to other disciplines. The idea that a public health nurse can offer supportive services to ex-patients and their families is a relatively new concept growing out of the situation described above.

In 1960, the State Board of Health received a financial grant from the National Institute of Mental Health for the purpose of developing a public health nursing program in after-care services to ex-hospitalized mental patients and their families. The program was developed with

the approval and cooperation of State Hospital personnel. Services on a limited basis are being provided in the 26 counties having generalized public health nurses, and on an intensive basis in Silver Bow and Deer Lodge counties. The Intensive Care Unit serves as a demonstration area and policies, procedures and techniques learned in these two counties are made available to public health nurses working elsewhere in Montana. Data which have been collected, while not as yet carefully analyzed, indicates that the public health nurse is a resource not to be overlooked in plans for community-based comprehensive care for the mentally ill.

## SUGGESTIONS

1. While the salaries of nurses at Montana State Hospital are comparable with those in general hospitals, consideration should be given through fringe benefits, higher salaries, etc. to compensate for the isolation of the Hospital and the nature and degree of illness of these patients. The primary source of the current supply of nurses is the surrounding towns of Anaconda and Butte; the majority of these nurses are married and have families which require them to live at some distance from the Hospital. Commuting between these towns and the Hospital often requires private transportation. Traditionally, salaries for nurses caring for psychiatric patients have been higher than for those working in generalized services.

2. Nursing educators agree that one of the most influential experiences in determining career choice is the exposure candidates receive while undergoing the basic program in nursing. Counseling and guidance to student nurses in the selection of the field of nursing

they will choose upon completion of their basic study of nursing is very limited -- if it is provided at all. This service to students would seem to be an appropriate responsibility of a school of nursing.

3. Continuing in-service educational programs for professional and practical nurses working with psychiatric patients is essential. Funds are needed to employ qualified personnel.

4. Statistics indicate that practical nurses tend to stay in one job longer than professional nurses or attendants. Consideration should be given to including more psychiatric orientation in the course for practical nursing.

5. Better communications between nurses and other professional disciplines working in the field of psychiatry is long overdue.

6. Nurses working in the psychiatric fields should be encouraged to become more active in their professional nursing organization. At the 1964 annual meeting of the professional nursing organization, a psychiatric conference group was established. This should provide an opportunity for all professional nurses interested in psychiatric nursing to meet for educational purposes.

## OTHER MANPOWER RESOURCES

In addition to the four professions studied in some detail - psychiatrist, psychologist, social worker and nurse - there are a number of other individuals who deal with the mentally and emotionally ill at various times in their professional careers. Foremost among these are teachers. Schoolteachers are very frequently confronted with students who manifest evidence of emotional and mental disturbance. Due to the demands upon their time, teachers are able to deal

with these problems only superficially; and, since the teaching load includes 20 to 40 students per class, it is not possible to deal with these problems in any depth. It would appear that schoolteachers should be assisted by complementary personnel, such as school social workers and school psychologists in consultation with psychiatrists. This would provide great opportunity for preventive work in mental hygiene. Another professional group dealing with the mentally ill, often those acutely disturbed, includes law enforcement officers who are involved directly with those who are often resistive or unable to accept proper help and treatment.

Judges, lawyers, clergymen and vocational rehabilitation counselors are also among those who are directly concerned at various times with the effects of mental and emotional illness. The more training, guidance and information provided these professions, the more effectively can the mentally and emotionally ill be dealt with.

One other manpower group exists which perhaps more directly than any other can deal with mental and emotional problems in children -- this group consists of the fathers and mothers in the state of Montana. It is almost axiomatic that the kind of environment, in terms of parental love, concern and guidance provided in the formative years of life, determines in main the mental and emotional health of the individual. Yet, the question is how to tap this power and how to direct the parents of these children constructively. If we continue to think only of treatment of those who are mentally ill, we will be forever fighting a losing battle since, in the foreseeable future, enough trained personnel to deal with all mental and emotional problems will simply not

be available. The final success of our endeavors in mental health depend on the provision of some preventive measures that will reduce the number who may require or need mental and psychological assistance. This can be accomplished by upgrading the stability of family life. The increasing divorce rate, a measure of the large amount of social disorganization prevalent in our society is mitigating against good mental health.

One potential source of power which remains virtually untapped, at present, is the educational system. A survey of educational courses taken by students in grade schools, high schools and colleges shows very little attention paid to the handling or control of mental and emotional problems. Little time and study are devoted to teaching students how to understand themselves, how to get along with one another, how to handle themselves in society or how to deal with the ever-increasing pressures of everyday life. The topic of courtship, marriage, and family responsibility is grossly neglected in the vast majority of educational systems not only in the state of Montana but throughout the nation. The assumption is that somehow one learns how to deal with other people and situations in life as some sort of natural process, the fact remains that this learning takes place through example set by adults and peer groups. Since family life in many cases manifests itself in fragmentation and disorganization and the standards of peer groups leave much to be desired, it seems appropriate that the educational system in school and in the church take cognizance of this condition and initiate programs of education to meet this need.

## SUMMARY

The greatest potential for the prevention of mental and emotional illness is the feeling of security within the individual himself and with his associates. Proper love and understanding given at the proper time can do much to prevent emotional disturbances. It is markedly evident that, in the final analysis, the cure or help given to individuals experiencing mental or emotional affliction depends upon the one-to-one relationship existing between the person troubled and the person attempting to help. The ever-increasing concern about the materialistic things in life leaves little time for concern for the more basic aspects of mental or emotional security, happiness and peace of mind. Until society begins to recognize and pay sufficient attention to these important factors, we can expect to continue to pay an ever-increasing price for this lack of wisdom and concern about these matters.

In order to utilize properly the manpower available, whether it be the parents, teachers, sheriff, social worker, psychiatrist, psychologist, clergyman, or the nurse, we must first decide what we really want to do in our communities and in the state. Once this decision has been made, then the manpower which is available or which can be mobilized can be focused upon the evident task. It is likely a two or three pronged approach to the problem of mental health and mental hygiene may be needed. Priorities need to be determined and from this proper allocation of manpower made. It is obvious that we cannot, all at once, drop our treatment programs in favor of a strong preventive program. On the other hand, if community education and a modification of school curriculum is indicated to alleviate the problem of emotional and mental

illness, then personnel skilled in changing public opinion and organizing lay people into active and potential forces should be employed. It may be that one of the greatest needs in the state of Montana, in terms of mental health, is a strong public relations program.

There is no question that poverty, economic deprivation and unemployment are important factors in the creation of stress, emotional illness and mental disturbances. On the other hand, it is equally true that great wealth and unlimited privileges do not necessarily insure a life of happiness and tranquility.

The utilization of mental health manpower now and in the future may be an important factor, either positively or negatively, in our national security. The experience of the instability of some of our fighting forces in South Korea adequately proves that our national security is imperiled by the emotional instability of the citizens who are asked to defend it in time of war. The number of rejectees for military service is increasing at an alarming rate. A great many of the rejections for military service are based on emotional and mental instability. The President's Committee on Physical Fitness encourages the development of strong athletic bodies; perhaps another committee should be organized which would encourage strong, stable and emotionally sound personalities.

A further summary of action which could be taken in the field of mental health manpower appears in the following excerpt from Public Health Publication No. 1027:[1]

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[1] U.S., Department of Health, Education and Welfare, A Mental Health Manpower Studies Program, Public Health Service Publication No. 1027, (March 1963), pp. 23-29.

The effective performance of special studies and research in the area of mental health manpower involves a number of conceptual considerations. These considerations should be recognized and allowed for in any over-all design or program for performing detailed studies and research on mental health manpower.

Such conceptual considerations involve a knowledge and awareness of the composition, general patterns and trends of the total labor force complex and how they relate to mental health manpower. Other considerations pertain to an awareness of the changes in the types of mental health manpower which will be needed in the future; trends in obsolescence and needs for retraining; recognition that shortages of manpower expressed in quantitative units is a function of utilization and that productivity is closely related to utilization in that the productivity of personnel depends on how and in what respect personnel is used.

. . . Geographic distribution and mobility involve such variables as climate, access to an intellectual atmosphere, economic benefits, and general working conditions within a given establishment. Included also are many subtle factors involving personal preferences and interpersonal relationships with other staff workers as well as the possibility for vertical mobility.

. . . Manpower shortages may be due in some instances to the maldistribution or to the improper utilization of the available supply.

. . . Preliminary data point to the existence of considerable attrition in various forms within the mental health manpower pool.

. . . It would be extremely valuable to study in more detail the patterns of attrition and their extent. Using knowledge about these patterns, plans to reduce manpower loss through attrition may be developed.

. . . Further attempts should be made to predict mental health manpower demand in the future.

. . . Prediction studies for comparatively short periods of time can be successfully made.

. . . Once estimates of the numbers of manpower needed at future dates are made and their theoretical limits determined, estimates of costs and financing must be performed. These estimates of costs can in some measure be based on existing information on costs of training in the field of mental health manpower. More detailed knowledge is necessary to know the cost of training professional and subprofessional personnel outside of the four core disciplines.

. . . Attempts are being made to more clearly define a given mental health worker at all levels, but continuing effort must be made in the future to sharpen the definition in terms of dimensional analysis . . . This involves the acquisition of data on various characteristics or dimensions of individual persons.

. . . Although some work and research have been performed on patterns among mental health personnel in the areas of occupational choice and career motivation, systematic and methodological studies need to be made.

. . . Closely related to the study of patterns of career choice, motivation and manpower attrition is the study of patterns of professional careers. It would be valuable to conduct research in this area on a sample basis to provide data on the variety of career backgrounds of professional personnel.

CHAPTER VIII

## TREATMENT PHILOSOPHY

Care and treatment of the mentally ill, to be most effective, must take place where the person lives and must include returning him as soon as possible to the community where the healthy adjustment is to be made. The best help a person can have can be obtained with local involvement which would include responsible action by family, friends, neighbors, professional persons, volunteers, volunteer organizations, and those with special experience, skill and concern. A basic concept of mental health centers is the team approach, and thus if it is to be "comprehensive", it will include all resources available in the community as well as at the special treatment facility.

The ever increasing problem of mental illness has resulted in overcrowding in many state mental institutions, and several have been expanded beyond a size conducive to good treatment procedure. Agreement is now widespread that mental hospitals operate more effectively when the bed capacity does not exceed 1,000. Recognition of the need for limiting the size of the state mental hospital is not a new concept for Montana. In a Montana State Hospital report dated 1915-1916, we find stated:[1,2]

> In connection with this, I respectfully submit the opinion that another state institution for the care of the insane in this state is apparent. A few other

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[1] Superintendent J. M. Scanland, M.D., "Unfinished Business - Montana State Hospital", Report to the Governor, Montana, 1915-1916.

[2] Montana State Hospital passed from private to state ownership on January 1, 1913. At the time the Hospital was taken over by the State of Montana there were approximately 800 patients. It is estimated that around this same number of patients was in Montana State Hospital in the years 1915-1916.

> buildings here might be added until another institution could be prepared for the reception of patients, but the number now present at this institution is, in the opinion of your superintendent, nearly if not quite as large as it should ever be.

The United States' national study, Action for Mental Health,[1] and Canada's counterpart, More for the Mind,[2] have both recommended that state hospitals be limited to 1,000 beds and that no additions be built to existing large hospitals. In addition, the studies state that community psychiatric hospitals should not exceed 300 beds.

During the late 1940's, community interest and awareness of the mental health needs of its citizens was intensified. During this period, community mental health clinics were established throughout the nation. These clinics made possible services to needy individuals in their home environment. In 1947, Montana began to develop its mental hygiene clinic system.

In the 1950's, day centers became an increasingly important part of the mental health program. Communities throughout the nation are presently indicating their interest as more are coming to acknowledge the importance of these new concepts in the treatment of the mentally and emotionally ill.

In the present decade, increased emphasis has been placed on the establishment of community based comprehensive mental health centers. This concept of treatment, as promulgated by most of the prominent

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[1] Joint Commission on Mental Illness and Health, Action for Mental Health, New York: Basic Books, Inc., 1961, p. xv,3.

[2] Committee on Psychiatric Services, More for the Mind, Toronto: The Canadian Mental Health Association, 1963, pp. 81-83.

authorities in the field of mental health and as defined in Public Law 88-164,[1] incorporates in its program all of the advances in psychiatric care and treatment this decade has produced as well as those in the preceding 20 years.

Fortunately, Montana's planners have defined "comprehensive center" primarily as a concept rather than just a building. It is felt that the term "center" has been confusing to many people, causing them to visualize the program as simply having the ultimate goal of constructing a building to treat the mentally ill. Early in the planning process, those responsible for the program felt it necessary to define "center" as the community and all its applicable resources engaged in a unified and coordinated effort designed to promote better mental health and mental health care. Here in Montana we do not experience some of the problems that face the larger, more densely populated, more complex sections of the nation. However, Montana has different problems, perhaps equally as difficult to solve, created by its large geographical area and relatively small centers of population.

The underlying concept is to maintain a continuity of care in the community -- this is basic. Continuity of care in this concept is important because:[2]

> A patient is a part of a community and should never lose that identification. Viewed broadly, there is continuity of service between outpatient and inpatient care which is related to the way in which the patient moves through his illness, i.e., from breakdown to

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[1] See Appendix B for a copy of Public Law 88-164.

[2] Ruth I. Knee, ed., Better Social Service for Mentally Ill Patients (New York: American Association of Psychiatric Social Workers, Inc., 1955), p. 43.

> hospitalization to improvement and rehabilitation. Hospitalization is an episode in treatment and not the entire treatment process. Service for the patient may, of necessity, be administratively divided, but something is lost if the whole treatment picture is not considered, i.e., treatment before hospitalization, during hospitalization, and after hospitalization. Hospitalization itself is related to social factors as well as medical factors. The presence or absence of family or community resources determines the need for hospitalization more frequently than does the actual degree of illness.

Here in Montana, "comprehensive" planning is not just planning for additional facilities, but also includes devising methods to utilize the less conspicuous and perhaps more important resources, such as home, church, school, and public agencies that plan either a supportive or preventive role.

In Montana, "community centered" means district centered rather than serving primarily a single city or county. Necessary buildings will be located in the larger centers of population within the state. The cities chosen must meet the criteria recommended by the Planning group as necessary to the provision of care to the people within the district. District centers are proposed for Missoula, Great Falls, and Billings.

Flexibility is a vital element within the philosophy of a dynamic treatment program. It should be evident in the total philosophy - not merely in the treatment agenda. Construction of treatment buildings should be regulated by the knowledge that the program they will domicile is <u>not</u> static, but rather subject to changes caused by advances in treatment methodology.

The essential components of a program within the concept of "comprehensive" treatment are the following five services:[1]

1. An inpatient service unit will provide treatment to patients needing 24-hour care. The size of each inpatient unit should be 20-25 beds, providing for two to four single bed rooms with the remainder of the unit having rooms of two beds each. Each unit will provide day and recreational space. Meals will generally be served in the day room area or in a separate dining area. It is not believed necessary to provide separate wards for segregation of sexes.

2. Outpatient care will be offered by the units to adults, children and families.

3. Partial hospitalization will offer day care and treatment for patients able to return home evenings. Night care may also be provided to patients able to work, but having need of further care or without suitable home arrangement.

The first psychiatric day hospital on the American continent was established in Montreal, Canada in 1946. This concept of day-night treatment programming is regarded by many psychiatrists as the most significant advancement in psychiatric care during this century.

A definition of the service is found in the following excerpt:[2]

> A therapeutic service for patients with mental or emotional illness or mental retardation who spend

[1] U.S., Department of Health, Education and Welfare, Public Health Service, Community Mental Health Centers Act of 1963, Regulations, Title II, Public Law 88-164, Sub-title 54.203 (May 6, 1964), p. 5952. Reprinted from the Federal Register.

[2] Anita K. Bahn, Sc.D., and others, Psychiatric Day-Night Units in the U.S., A Report Presented at the First International Congress of Social Psychiatry, London, U.S., August 17-22, 1964, (Bethesda, Md.: The Congress 1964), p. 2.

> part of the day or night in a planned treatment program in the unit and in which a psychiatrist is present on a regularly scheduled basis who assumes medical responsibility for all patients.

The service rendered to the patient falls between that offered by an outpatient psychiatric clinic and hospitalization in a state mental institution. Suggestive of the philosophy of the day hospital is the following statement taken from Action for Mental Health:[1]

> Cameron makes it clear that three assumptions underlie day hospitals -- patients do not need to stay in bed; they do not need to stay in the hospital until they are well and should not remain in the hospital when they are able to leave; and treatment should not be limited to the patient but must include the family and home and his social setting.

In 1963, an estimated 114 day-night units were in operation; while in 1964, an estimated 142 were in operation - an increase of nearly 20 percent.

4. Emergency care. Twenty-four hour service will be available within at least one of the first three services -- inpatient, outpatient, and partial hospitalization. Emergency services are perhaps more appropriate in metropolitan areas, since communication and accessibility present some real problems in rural areas. However, this factor illustrates the need for imaginative planning to develop new ideas which can effectively cope with this problem and others.

5. Consultation and education will be available to community agencies and professional personnel. Consultants will be fully trained professionals, interested in community service, who will provide consultation

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[1] Joint Commission on Mental Illness and Health, Action for Mental Health, Final Report (New York: Basic Books, Inc., 1961), pp. 180-181.

and moral support essential to individuals working with the emotionally ill. The professionals can help develop stronger common interest and support for the emotionally handicapped within the communities. Many persons interested and involved in promoting good mental health can, with a little education from professionals in the field, offer substantial assistance as counselors to those with mental and emotional problems. This philosophy is summarized very well in the following statement:[1]

> A host of persons untrained or partially trained in mental health principles and practices -- clergymen, family physicians, teachers, probation officers, public health nurses, sheriffs, judges, public welfare workers, scoutmasters, county farm agents, and others -- are already trying to help and to treat the mentally ill in the absence of professional resources.

In Montana, the use of partially trained persons has additional meaning when viewed from the lack of specific social agencies designed to offer treatment to the individual patient. A continued emphasis on educating the general public to the problems of mental illness is needed in Montana. This program should include the combined efforts of private and public agencies, as until the public has enough understanding of problems involved, the stigma now attached to mental illness will continue to block progress at all levels. The public needs to know that the mentally ill can be helped, and mentally ill persons need to know that there are those who care about their problems. Public education should be coordinated through the Mental Health Authority.

The foregoing five elements of service are by definition essential to a comprehensive treatment center program. The following services

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[1] Ibid, p. xii.

are necessary to complete the treatment program and enable it to function as fully as desirable:

6. Diagnostic service will provide diagnostic evaluation and may include recommendations for appropriate care.

7. Rehabilitation service will include both social and vocational rehabilitation. Pre-vocational testing, guidance counseling and job placement services will be offered. The ex-patient will be helped to develop a skill, to find a position in which to use his skill and will be given assistance to maintain his job once it is obtained.

8. Pre-care and after-care service provides screening of patients prior to hospital admission, and home visiting before and after hospitalization. Follow-up services for patients will be available in outpatient clinics, or in foster homes, half-way houses, or in the patients' own homes.[1]

9. Training will be made available to all mental health personnel.

10. Research and evaluation of the center program should be established. It is vital to have sufficient data to evaluate the effectiveness of the program. If effective and efficient utilization of personnel is maintained, it will be necessary to continuously audit the program's direction.

Treatment is the primary function of the mental health professional. If there is undue demand on his time for paper work or other distracting

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[1]The importance of treating patients in their own homes is presented by Professor Joseph Andriola, School of Social Work, University of Oklahoma. His paper on "Some Introductory Remarks Regarding the Treatment of the Mentally Ill in a Home Setting" was presented at a Veterans Administration Seminar in Huntington, West Virginia, November 9, 1956.

jobs, then his time will be lost from the treatment program. The center will need adequate staffing in clerical, housekeeping, food service, etc. to enable its professional staff members to devote as much of their time to treatment as possible.

All personnel who have direct or indirect contact with the patient should receive continued training through staff development programs. The importance of the role every employee plays in a therapeutic program cannot be over-emphasized. Each employee's attitude has direct bearing on the development of a healthy climate in the psychiatric ward.

The following excerpt is an example of what is meant by therapeutic and non-therapeutic attitudes:[1]

| THERAPEUTIC | NON-THERAPEUTIC |
|---|---|
| Respect for the patient | Impersonality |
| Acceptance of the patient as he is now | Acting as though patient is a child or a fool |
| Lack of fear of expressions of hostility | Revenge and retaliation |
| Hopefulness about patient's ability to change | Hopelessness |
| Permissiveness with limits to acting out | Punishment for non-conformity |
| Devotion to patients | Attacking self-esteem |
| Encouragement to take responsibility | Fostering dependency |
| Consistent management | Erratic direction -- confusion in aims |
| Individualization | Regimentation |

[1] Ruth I. Knee, ed., Better Social Services for Mentally Ill Patients (New York: American Association of Psychiatry, Social Workers, Inc., 1955), p. 12.

## PROGRAM PHILOSOPHY

A mental health program philosophy embodies the widest use of care and after-care in the community and the utilization of every available community resource. Local cooperation is a must if this concept is to be successful. "In mental health, as in all fields, individuals and agencies sometimes regard their own particular theories and practices as superior, and tend to subordinate if not refuse to recognize others."[1]

Stanley W. Boucher, ACSW,* Assistant Director of the Colorado Mental Health Planning Project, has further developed the concept of "hubris" as first defined in Greek classical literature. He interprets "hubris" as blinding pride, and believes it to be an enemy of all planning. The point Mr. Boucher makes is that the more professional and better prepared one becomes in his particular field of endeavor, the more difficult it becomes for him to work with other professionals. If this concept is related to local communities with consideration of their communalistic attitudes and interests, it becomes clear that planning must be carefully formulated to make it effective. Communities must come to a full awareness of the need for inter-cooperation as political subdivisions of the counties and state and of the need for intra-cooperation within the resources contained within their own boundaries.

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[1] U.S., Department of Health, Education and Welfare, Public Health Service, Concept and Challenge, The Comprehensive Mental Health Center (Bethesda, Maryland: National Institute of Mental Health, April 1964), p. 21.

* Academy of Certified Social Workers.

Integration and coordination are fundamental principles that must be observed if success is to be realized.[1]

> This need for integrated service in a community has many interesting aspects. It means that instead of the several agencies which in the aggregate make up the community, it is sounder to think of the community as one comprehensive agency for its people. Then public health, education, social work, public safety, industry, church, recreation, court, and other agencies become parts of the whole -- parts that depend on each other. No longer then can anyone of these claim full authority even within its own sphere. The practical point of this is that mental health planning for a community cannot be restricted to the agencies that are specifically labeled "mental health". The mental health of the community is in the hands of the schools, the churches, the courts, the social agencies and the many other organizations.

Members of the professional staff must be given freedom to exercise their individual talents and imagination in developing a meaningful program. Ideally, program development should be at such a high level of competence that the professional individual's involvement therein will be so intense that he becomes an inseparable part of the dynamic processes involved in its construction.

The use of volunteers should be encouraged. Their service has benefited numerous patients in mental hospitals throughout the nation. Montana State Hospital has many volunteers who have given long hours of service to patients. The presence of volunteers in hospitals has long been recognized as being therapeutic for patients. The use of volunteers has also freed many professional staff members from routine administrative matters thus enabling them to spend more time in therapy with patients.

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[1] Warren C. Lamson, "Integrating Mental Health Services into the Community Health and Welfare Program", Journal of Psychiatric Social Work (September 1955), pp. 243-249.

Whenever possible, the admission of patients to mental health facilities should follow the same procedure as admissions to general hospitals. Senate Bill No. 7 attempted to change existing laws concerning the admission procedures for individuals needing psychiatric care. The state Planning Committee believed that the section of the revised law concerning admission procedures was poorly conceived and the Committee testified against it. The section of Senate Bill No. 7 concerning mental health laws was amended so extensively it lost its original intent. It is recommended by the Planning Committee that new legislation is needed to facilitate admission procedures into general hospitals as well as state mental hospitals. Every care must be exercised to protect the rights and privileges of the individual.

A commission should be appointed, made up of individuals with a continuing interest in mental health, with special emphasis on representation from the professions of law and medicine. This commission will study revision of the mental health laws and make recommendations to proper authorities that will assist in the implementation of better practices.

Insofar as possible, the illness of a mental patient should be identified with symptoms rather than "labeling" the individual with a diagnosis. The jargon or terminology of psychiatry has, in some instances, become pejorative to the condition of those treated. As an example, when physicians sign voluntary commitment papers for a person desiring admittance into the State Hospital, care should be exercised so that where possible a patient's condition is described by symptoms rather than branding him with diagnostic impressions. Voluntary applications are returned to the patient at the time of his release from

the State Hospital; and thus he and his family have access to the terminology used on the application. In many cases, knowledge of being labeled a "schizophrenic" or other diagnostic term adversely affects the motivation of the patient and/or his family members to successfully meet the challenges presented. In such cases, this knowledge undoubtedly contributes to feelings of hopelessness. Dr. Karl Menninger, who is often referred to as the dean of American psychiatrists, recently wrote an article entitled "Psychiatrists Use Dangerous Words" in which he wrote:[1]

> I avoid using words like schizophrenia just as I avoid using words like "wop" and "nigger". I know what people mean by these names, but I dispute their specificity; they chiefly denote an attitude of the speaker toward skin color or foreign birth, and their use can do great harm.

"Branding" a patient with a word or words can be as lasting as the brand a rancher burns on the flanks of his cattle, and it certainly has much more profound implications to the recipient.

The psychiatric team is the functional unit of the comprehensive mental health center. This team will be staffed with a psychiatrist who is the team leader holding medical responsibility for the team's patients. A psychologist, two social workers, 11 registered nurses, and 10 psychiatric aides complete the team's staff. Chart 8.1 shows a suggested organization chart for a comprehensive mental health center.

The comprehensive center is visualized as having within its staffing

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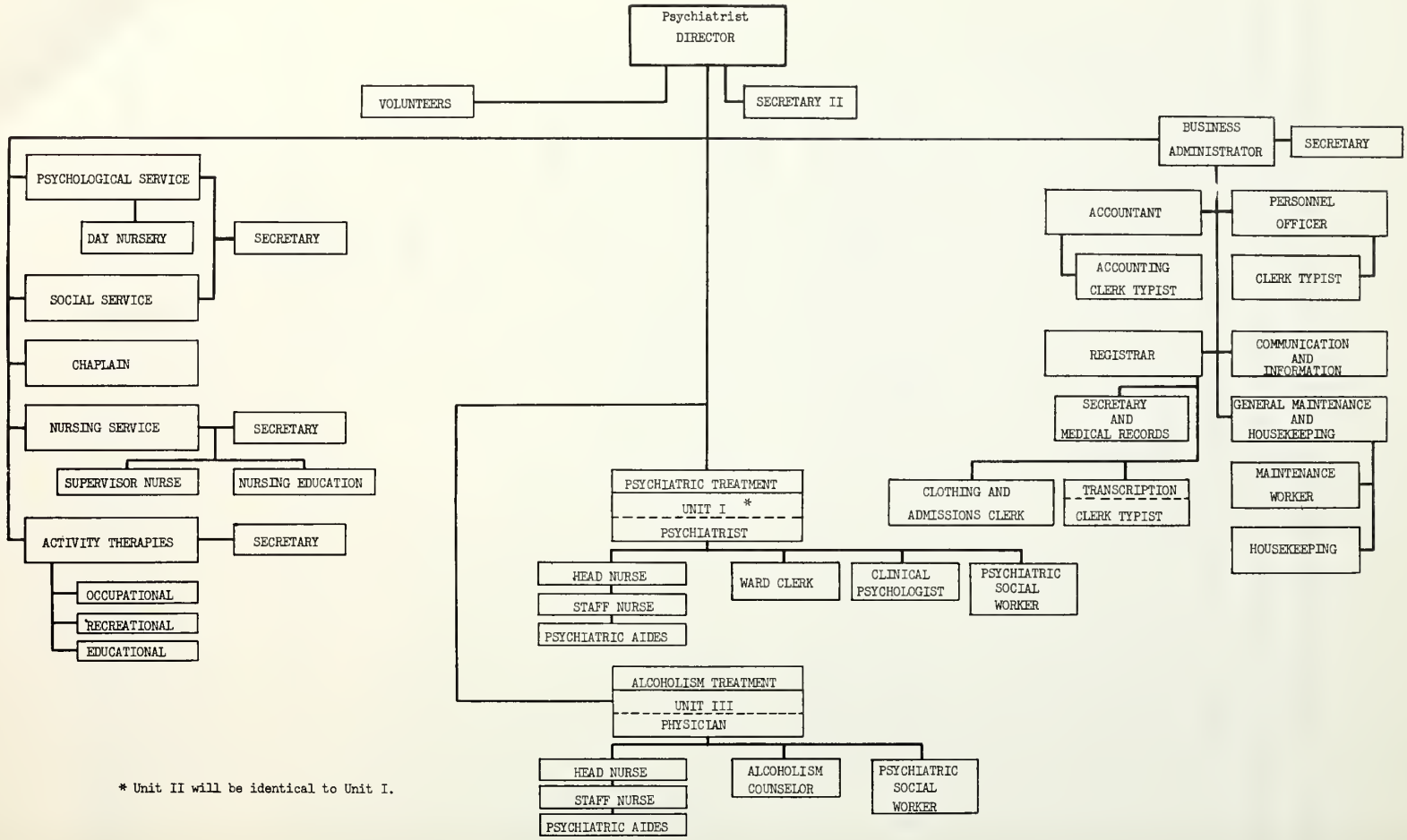
[1] Karl Menninger, M.D., "Psychiatrists Use Dangerous Words", The Saturday Evening Post, (April 25, 1964), p. 12.

CHART 8.1

COMMUNITY COMPREHENSIVE CENTER
ORGANIZATIONAL CHART




* Unit II will be identical to Unit I.

complement two such psychiatric teams each having responsibility for:

| | Number |
|---|---|
| 24-hour patients | 15 |
| partial hospitalization | 20 |
| family care | 5 |
| pre-care and after-care | 35 |
| | 75 [1] |

From admission of the patient to his final disposition, a team will retain responsibility for patients assigned to it. The team staff will be engaged in both inpatient and outpatient care and thus feasibly could care for a patient on a pre-admission basis.

Trained psychiatric nurses are in short supply. It is anticipated that most of the nursing staff on the team would not have psychiatric training, and deemed probable that only the chief nurse and the head nurses would be thus qualified. Too often these supervisory nurses become bogged down with administrative matters and have too little time to spend in patient treatment.

To alleviate this situation, the charge aide can relieve a head nurse of some of the routine administrative detail such as checking and issuing supplies and assigning ward housekeeping duties. Ward clerks can process routine paper work and be of further assistance in freeing the supervisory nurse for the more important function of patient treatment.

Within the center there will be a 10-bed alcoholic unit. The alcoholic unit's staff under the direction of the psychiatrist director should consist of a physician, an alcoholism counselor, a psychiatric

[1] In no way should these suggested allocations be considered inflexible. Unit "teams" will hopefully have the final discussion as to numbers based on need.

social worker, six registered nurses and five psychiatric aides. The Alcoholics Anonymous program and other community resources should continue to support the individual in the community following a treatment period at the comprehensive mental health center.[1]

## THE ROLE OF THE MENTAL HYGIENE CLINIC IN THE COMPREHENSIVE CONCEPT

Mental hygiene clinics in the outlying districts will be an integral part of the comprehensive mental health center under the Division of Mental Hygiene. The Planning Committee stressed that a continuum of care and collaboration with related services such as public health nursing, general practitioners, etc. and such liaison as necessary to provide continuity, was vital to good programming. Because of Montana's large geographical area and the resultant long distances that patients must travel for treatment, a termination of services at the comprehensive center followed by a subsequent transfer of the patient to a more accessible mental hygiene clinic will be necessary in some instances. In cases thus affected, pre-care, after-care, and follow-up services will be provided by mental hygiene clinic personnel rather than by a comprehensive center team. Clinics should have available to them laboratory facilities, possibly by contract with a local hospital, to make available to indigent patients necessary lab studies. This will require close coordination of effort between units of the total service.

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[1] Supra, Chapter on Supportive Facilities and Resources, p. 143 for a map showing the distribution of those individuals or groups interested in helping the alcoholic to live a life of sobriety.

## THE ROLE OF MONTANA STATE HOSPITAL IN THE COMPREHENSIVE CONCEPT

Montana State Hospital will continue to play an important role in the comprehensive mental health program. The district concept will take years to develop and implement. Those districts without treatment programs will still be reliant upon Montana State Hospital to furnish treatment until they can develop their own. When necessary, the district centers will initiate referral to Montana State Hospital; however, the centers still would provide follow-up care and rehabilitation upon release of the patient. Under such a program, the patient could move easily from one treatment and/or treatment source to another as his case may indicate. This type of patient movement or "continuity of care" is a basic concept in the philosophy of comprehensive mental health treatment, and represents the most advanced concept in psychiatric treatment concerning care of the mentally ill. The Planning Committee has been keenly aware that Montana State Hospital must remain a part of the over-all planning, and that its function will remain a vital one in Montana. To meet present and future demands, Montana State Hospital will have to develop a program of replacement and remodeling of existing buildings. However, the size of this institution will gradually decrease as district treatment resources become available.

## THE NEED FOR CONTINUED PLANNING

The Planning Committee recognizes the need for planning as an on-going and integral process in the mental health program. The absence of planners does not mean that planning is not being accomplished; however, it does indicate in most instances that the planning will be informal,

unorganized and inefficient. These statements are especially valid when viewed from the operation of a large program.

## THE NEED FOR CONTINUED RESEARCH

A common contention is that legislators are not interested in research facts. This, however, did not prove to be the finding of the project's staff who frequently worked long hours to furnish legislators with information the lawmakers requested during the 39th Legislative Assembly. It should be recognized that planning is a basic fundamental process common to all men in all kinds of activity.

Planning for mental health in Montana is not completed with publication of this volume. Very often material is read, filed and forgotten due to the press of keeping up with current activity. For these reasons. planning must be as dynamic as the entity it plans for, as applicable to its environment as men can devise, as accurate as mind and machine can produce it. Yet it must maintain a level of comprehensibility commensurate with the understanding of all who must utilize its product. To be effective and meaningful, it must be continuant.

Chart 8.2 is indicative of the flow of information as it is gathered through research, and the effect that this research has on the determination of the objectives in a program of treatment.

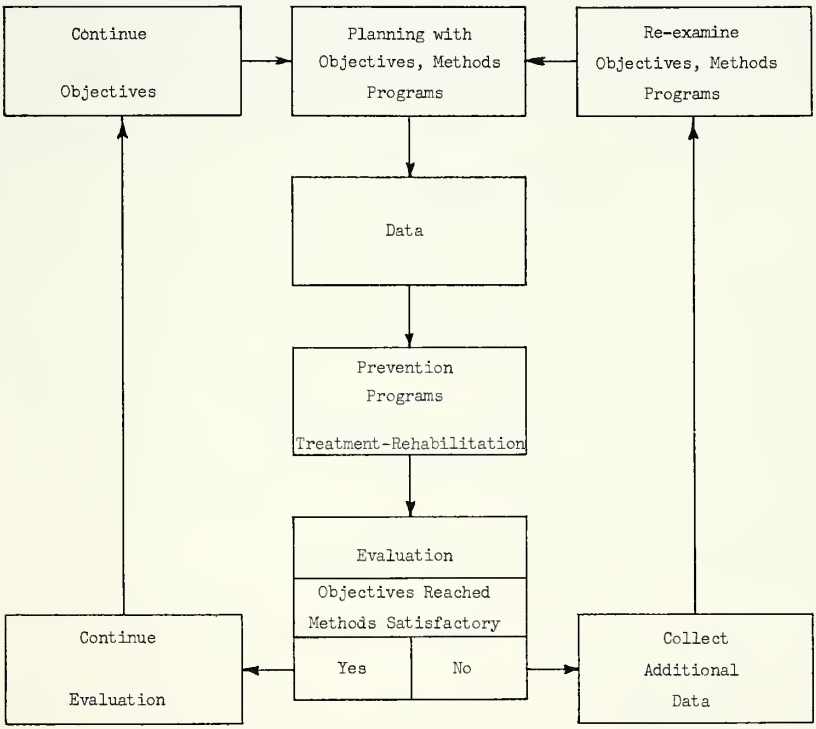
## COUNCILS

### CITIZENS' COUNCIL

Within each of the three comprehensive districts, a citizens' council should be formed to serve as an advisory body. It is suggested that the composition of a council consist of representatives from citizens'

CHART 8.2

RESEARCH AND EVALUATION FLOW CHART



and professional groups within a district's catchment area. The representation would be from appropriate associations or significant groups characteristic of the community. A nucleus body could be formed from groups such as: Montana Association for Mental Health, Montana Association for Retarded Children and Adults, League of Women Voters, Montana Education Association, Montana Federation of Women's Clubs, Montana Nursing Home Association, local school boards and school administrators, P.T.A. groups, probation and law enforcement people, American Association of University Women, veterans' organizations, and other appropriate organizations. This council could be enlarged as the program develops.

The citizens' council could function in four major areas: (1) as liaison between the comprehensive mental health district centers and the organizations they represent; (2) as data-collectors; (3) as a body to make recommendations to the district mental health director as to community priorities and program needs; and (4) as support for mental health in local communities within the catchment area.

ADVISORY COUNCIL OF STATE AND FEDERAL AGENCIES

This council would serve as an advisory council to the State Department of Public Institutions. It should be composed of the following members of state government: Director of Department of Public Institutions (chairman of the council); Executive Officer of the State Board of Health; State Superintendent of Public Instruction; Director of the Division of Vocational Rehabilitation; Administrator of the Department of Public Welfare; Chairman of the Unemployment Compensation Commission, and Chairman of the Governor's Joint Committee on Mental Health and Mental

Retardation. In addition to these, two members from federal government agencies should be council-members: the Director of Indian Health Service and the Director of the Veterans Administration.

The council would have three major functions: (1) to insure coordination of comprehensive services as established; (2) to make resources available for special and ongoing projects; and (3) to act as liaison between the Department of Public Institutions and related state and federal agencies.

## PROPOSED TREATMENT COMPLEX

In the beginning phases of development of the community center concept, the project's Planning Committee was only concerned with fostering plans for the construction of a community mental health center. As planning progressed, it was deemed advisable to consult with the retardation planners in an endeavor to harmonize the total program into a unified effort. The Planning Committee felt that such a union would be expedient from two main vantages: (1) a saving could be realized in construction through common usage of certain of the facility's elements; and (2) there could be like savings in the utilization of professional personnel. The alliance also could produce a stronger platform from which to launch a request for enabling legislation. It was soon apparent from planning meetings that a third need was coming into focus for serious consideration. This was the need for state attention to juvenile correction and rehabilitation.

Although such a tripartite was a new concept to Montana, and perhaps to the national scene, it was adopted by the planning groups as a functional

conceptualization well related to the particular problems confronting Montana, and representative of a truly comprehensive service. (For a schematic presentation of the triad, please refer to Chart 8.3.)

Vital to the correct comprehension of the "community health center" is the distinct understanding of the autonomous nature of each service. Each section would have separate administrators with total responsibility for treatment processes in their section. Each section would have its own staff responsible only for the conduct of its particular program. However, an evaluation team, common to all sections, could classify the patient on admission and place said patient into the proper section.

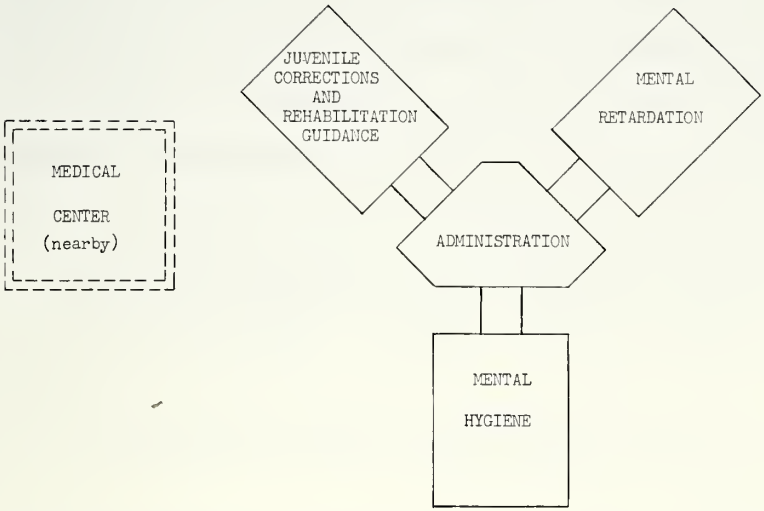
The three services would share in common the functions of the center's business administration, e.g., food service, maintenance, and communication. This merger of appropriate activities would make possible substantial reduction in operational costs over separate construction and subsequent operation of disunited services.

A very significant factor, if not the most significant, is that the coalition of these services into a complex as above described would make possible utilization of complementary staff personnel. Staffing patterns are sufficiently similar to make provident the inter-section usage of some professional personnel. As an example, psychiatric services would be significantly involved in the programs of all three sections.

With proper coordination of services, this tri-function complex could, upon completion, be a significant addition to Montana's over-all treatment program.

CHART 8.3

COMMUNITY HEALTH CENTER
(For diagnosis and treatment)




JUVENILE CORRECTIONS AND REHABILITATION GUIDANCE SECTION: Administrator responsible to Director and Board of Institutions (Coordinated with institutions at Helena and other institutions)

MENTAL RETARDATION SECTION: Administrator responsible to Director and Board of Institutions (Coordinated with institutions at Boulder and other institutions)

MENTAL HYGIENE SECTION: Psychiatrist Administrator responsible to Director and Board of Institutions through Supervisor of Division of Mental Hygiene (Coordinated with Montana State Hospital and Mental Hygiene Clinics and other institutions)

ALL will be under State Merit (or Civil Service) System and
DEPARTMENT OF INSTITUTIONS

CHARACTERISTICS OF CONSTRUCTION
PSYCHIATRIC UNIT

There are a great many programs designed to provide better patient care. It is certain that any treatment program will be influenced by its particular setting. However, as discovered in a survey conducted by Dr. Morris S. Schwartz, director of the study of mental patient care for the Joint Commission on Mental Illness and Health, predominant trends or "themes" are general in the field. These "themes" are:[1]

> In the outpatient system: providing immediate help for the emotionally disturbed, extending the outpatient system in the community, and broadening the conception of help.
>
> In the inpatient system: individualizing care and treatment, breaking down the barriers between the hospital and the community, and developing a therapeutic milieu.
>
> In the ex-patient system: tailoring care to ex-patients' needs, grading stress, and providing continuity of care.

The physical design for a psychiatric unit is different from that for other medical services, e.g., surgical service. Developments in psychiatry in the past decade have considerably changed the pattern of care and treatment. Wards caring for the most disturbed patients have become much more manageable with the advent of tranquilizers.

Although drugs have admittedly been instrumental in assisting the disturbed patient to maintain a functional level, experience shows that pleasant environment also makes a meaningful contribution to improvement

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[1] Joint Commission on Mental Illness and Health, Action for Mental Health, Final Report (New York: Basic Books, Inc., 1961), p. 169.

of patient behavior.[1] Colors and materials used in the facility should be bright, cheerful and comfortable. All physical characteristics of a psychiatric facility play an influential role in milieu therapy. The drama reported in the book, Experiment in Living, gives a "picture story . . . . (that) concerns an enormous, energetic and ambitious project by a group of volunteer workers to alter the physical surrounding in parts of a large psychiatric hospital".[2] The total environment in the treatment of psychiatric patients is of considerable importance and must be considered in architectural planning.

Treatment of psychiatric patients has changed significantly in a relatively short time. The psychiatric facility must be so constructed as to be flexible. In the federal act which describes the community mental health center, we find this flexibility is stressed.[3]

> All facilities shall be designed and constructed so as to permit maximum flexibility in the proposed uses of those facilities. Provisions shall be made, wherever possible, for future expansion of the floor areas and the relocation of interior partitions.

Considering the dynamic nature of ideas and methods in treatment of the psychiatric patient, a high degree of collaboration is in order between the architect and those who have direct responsibility for the mentally ill person, e.g., psychiatrist, nurse, social worker, psychologist, and other personnel on the treatment team.

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[1]John W. Cronin and Wilber R. Taylor, Environment for Mental Therapy, Mental Hospitals, No. 240 (November 1956), pp. 201-231.

[2]Dorothy Schloss, Experiment in Living (University of Texas: The Hogg Foundation for Mental Health, 1964), p. 3.

[3]U.S., Department of Health, Education and Welfare, Public Health Service, Community Mental Health Centers Act of 1963, Public Law 88-164, Title II, Sub-title 54-215 (b). Reprint from Federal Register (May 6, 1964). See Appendix B.

Listed below are other guidelines that the project would recommend be included in the structure of a center:

1. Sufficient office space and conference rooms to enable the treatment personnel to carry on an adequate patient interview and individual and group therapy.

2. A meeting hall of sufficient size to provide an area in which liaison activity could be carried on with the community.

3. Space in which to carry out social programs for the patients. The psychiatric patient is usually ambulant and dressed in street clothes, and there must be area provided to fill his social needs. This space is no less important than adequate individual therapy space. This will include space for day activity, recreational area for indoor and outdoor activities, and space for occupational therapy.

4. Space should be provided for community education and training of mental health professionals.

5. The comprehensive center should be constructed close to a general hospital which can furnish emergency and routine medical support. Aligning the psychiatric center with a general hospital will help prepare for a near future time when services for mental disorders will be similar to those now available for physical ailments.

CHAPTER IX

## SURVEY OF NEED

During the course of the project, an attempt was made to determine the relative need for mental health services of each county and district throughout the state. "The 'relative need' refers to the degree to which the mental health needs of an area are unanswered by existing resources."[1] The Planning Committee preferred to present need under the broader categories of comprehensive mental health districts and sub-districts rather than by individual county. Information with regard to the extent of mental disorder, the availability of mental health resources, the availability of mental health manpower, areas of unemployment, school problems, delinquency, and many other important factors were sought in determining the need for mental health services.

A substantial grouping of data involving admission information from the state's institutions plus other sources, including the 1960 census, were utilized and statistically translated into 98 variables. The Denver Health, Education and Welfare Regional Office was instrumental in making available to the project much valuable information with regard to the procedural analysis of the variables. From the 98, 41 variables were selected in two particular program areas: (1) need for prevention service, and (2) need for treatment and rehabilitation services.

Raw scores for each variable were computed for each of the counties of the state. The raw score was then standardized by the use of a T-score,

[1] U.S., Department of Health, Education and Welfare, Public Health Service, National Institute of Mental Health, Guideline for State Plans, The Community Mental Health Centers Act of 1963, p. 4, paragraph C.

a recognized mathematical method for standardizing scores. Each county's population was adjusted to the nearest thousand and its T-score was weighted by this adjusted population. These weighted T-scores were then averaged, and an average score was calculated for the several comprehensive mental health districts and the mental hygiene districts. It is vital to the proper comprehension of these reported scores that they NOT be interpreted as percentages.

It must further be understood that the mean point of a score is 50. With this in mind, it is then possible to evaluate the reported score on the basis of its deviation from the mean. The number of points of deviation determine its relative significance. A movement up the scale indicates a variable more significant to establishing the reported index or need than at least half of all other variables considered. A downward movement on the scale indicates a variable less significant to establishing the specific index; again, the amount of deviation from 50 determines the relative significance.

The standardized score can be compared from one district to another within each main grouping, e.g., the average district score for "prevention" in Missoula can be compared to the same score for "prevention" in Great Falls or Billings. For a complete breakdown of variables presented by county, refer to Appendix A.

## NEED FOR PREVENTION SERVICES

The first program area - need for prevention services - includes six indices (A through F). Thirty-one variables are represented in the six indices under this program of need.

A. Stress Associated With Rapid Urbanization

1. Percent of total population - urban
2. Percent urban population increase 1950-1960
3. Percent of total population - rural farm
4. Percent of families with incomes under $3,000
5. Population
6. Uniform crime rates - burglary
7. Uniform crime rates - auto theft
8. Uniform crime rates - total crimes
9. Median family income
10. Population density - persons per square mile
11. Percent of civilian labor force which is female
12. Percent of employed civilians holding white collar jobs

B. Need for Prevention and Rehabilitation Services for Children

13. Per capita state and county expenditures for Aid to Dependent Children
14. Percent non-white
15. Percent of population under 18 years old
16. Total population per household
17. Percent of population under five years old
18. Median age
19. Percent of housing units with 1.01 persons or more per room
20. School drop-out rate (corrected for migration)

C. Crime of Violence

21. Suicide rate by place of residence
22. Uniform crime rate - forcible rape
23. Uniform crime rate - aggravated assault

D. Disrupted Marriage Ratio

24. Disrupted marriage ratio

E. Economic Disequilibrium

25. Per capita state and county expenditures for Old Age Assistance
26. Percent unemployed
27. Mean personal income
4. Percent of families with incomes under $3,000
28. Percent of housing units without plumbing facilities
19. Percent of housing units with 1.01 persons or more per room

F. Use of Correctional Facilities

29. Male first admission rate to State Prison
30. First admission rate to the Girls' Vocational School
31. First admission rate to the Boys' Industrial School

## NEED FOR TREATMENT AND REHABILITATION SERVICES

The second program area - need for treatment and rehabilitation service - includes seven indices (A through G). Twenty-two variables are represented in the seven indices under this program.

A. Distance to Treatment Resource

32. Mileage from county seat to Montana State Hospital

B. Old Established Population in an Old Established Community

33. Percent population increase 1950-1960
34. Percent of population age 65 and above
35. Percent of male population age 19-34
36. Population over age five living in same house in 1960 as in 1955
37. Percent of housing units in structures built in 1950 or later

C. Stress Associated With Rapid Urbanization

1. Percent of total population - urban
2. Percent urban population increase 1950-1960
3. Percent of total population - rural farm
4. Percent of families with incomes under $3,000
5. Population
6. Uniform crime rates - burglary
7. Uniform crime rates - auto theft
8. Uniform crime rates - total crimes
9. Median family income
10. Population density - persons per square mile
11. Percent of civilian labor force which is female
12. Percent of employed civilians holding white collar jobs

D. Alcohol

38. Per capita expenditure for liquor

E. Admission Rate - Montana State Hospital

39. Age adjusted first admission rate to Montana State Hospital adjusted for effect of distance from county to hospital

F. Admission Rate - Mental Hygiene Clinic

40. Age adjusted first admission rate to mental hygiene clinics

G. Financial Assistance Program

41. Per capita state and county expenditures for Aid to Permanently and Totally Disabled

The adjusted scores for the indices relating to the aforementioned services programs will be presented in the following charts entitled "Indexes Related To Need, Form A". The following explanation of Forms B through D is present to clarify the intent of these additional forms. A complete set of forms, A-D, is included for each of the three comprehensive community health districts.

Form B. This form graphically presents all of the first admission rates by comprehensive districts into the public and private facilities listed. The upper two-thirds of the graph presents the facilities independently thus allowing for visual comparison of public and private facilities. The lower third of the graph combines all of the public facilities under one heading and all private facilities under another heading, and reports them accordingly. The relative position of one district compared with the other two can be determined by comparing the several forms.

Form C. There are three of these forms in each section -- one for each of the clinic sub-districts found within the larger comprehensive district. These graphs indicate the first admission rates into public and private treatment for each of the sub-districts as noted.

Form D. There is one of these in each section. This form presents information with respect to mental health resources available within each comprehensive district and clinic sub-district. Form D reports those facilities that are available to mentally ill individuals, and also the professional manpower found within the districts. To avoid difficulties encountered in attempting to precisely define each discipline, all persons who are employed under the name of a discipline

SECTION I.
MISSOULA COMPREHENSIVE MENTAL HEALTH CENTER DISTRICT
AND CLINIC SUB-DISTRICTS

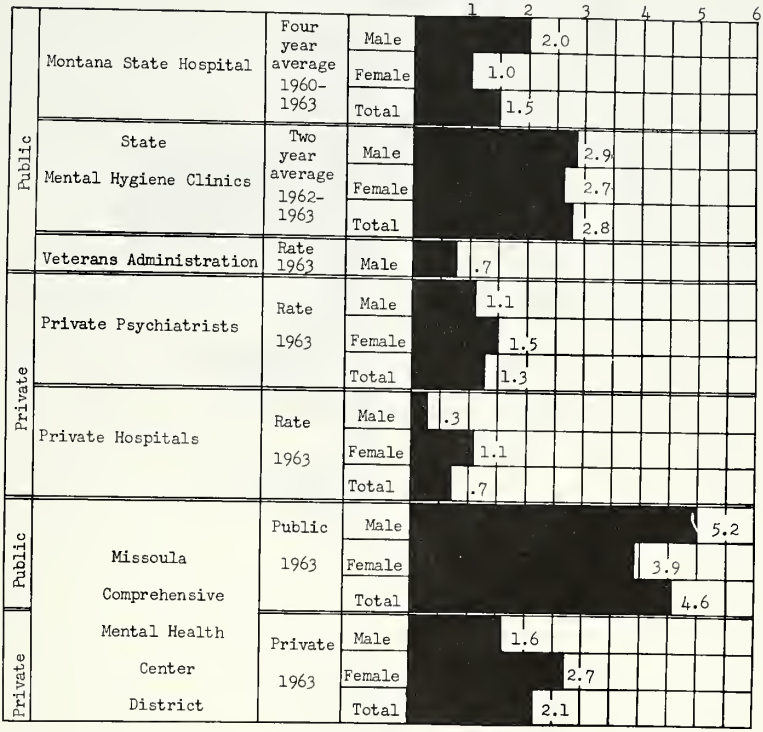
FORM A

INDEXES RELATED TO NEED

| PREVENTION | AVERAGE DISTRICT SCORE | MENTAL HYGIENE DISTRICT WEIGHTED SCORE | | |
|---|---|---|---|---|
| | MISSOULA | KALISPELL | MISSOULA | BUTTE |
| A. Stress Associated With Rapid Urbanization | 54.28 | 51.26 | 54.33 | 57.51 |
| B. Need for Prevention and Rehabilitation Services for Children | 47.96 | 50.78 | 46.38 | 47.34 |
| C. Crime of Violence | 50.92 | 50.56 | 50.64 | 51.54 |
| D. Disrupted Marriage Ratio | 49.55 | 44.49 | 47.30 | 56.11 |
| E. Economic Disequilibrium | 48.54 | 51.89 | 47.62 | 46.78 |
| F. Use of Correctional Facilities | 50.43 | 51.48 | 46.05 | 54.24 |
| AVERAGE | 50.28 | 50.08 | 48.72 | 52.25 |
| TREATMENT AND REHABILITATION | | | | |
| A. Distance to Treatment Resource | 40.36 | 48.22 | 40.28 | 34.01 |
| B. Old Established Population in an Old Established Community | 49.85 | 50.08 | 51.13 | 48.28 |
| C. Stress Associated With Rapid Urbanization | 54.28 | 51.26 | 54.33 | 57.51 |
| D. Alcohol | 52.99 | 45.46 | 48.78 | 63.67 |
| E. Admission Rate - Montana State Hospital | 54.45 | 54.37 | 46.88 | 62.62 |
| F. Admission Rate - Mental Hygiene Clinics | 64.05 | 52.01 | 78.79 | 58.14 |
| G. Financial Assistance Program | 53.50 | 51.05 | 49.75 | 59.57 |
| AVERAGE | 52.78 | 50.35 | 52.85 | 54.83 |
| OVERALL AVERAGE | 51.63 | 50.22 | 50.94 | 53.64 |

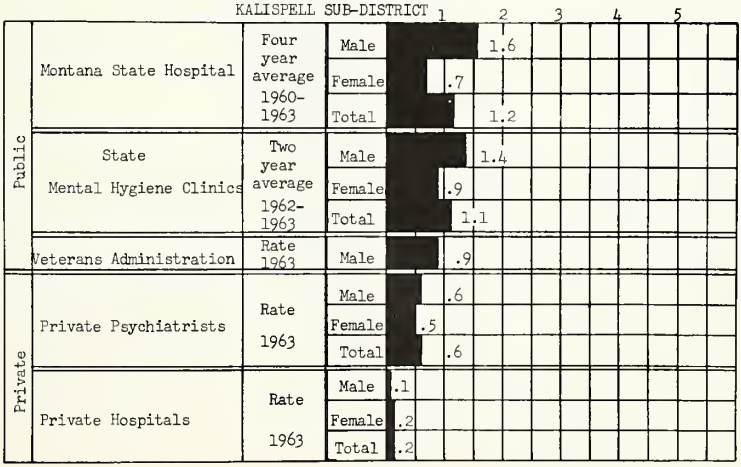
FORM B

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
MISSOULA COMPREHENSIVE DISTRICT



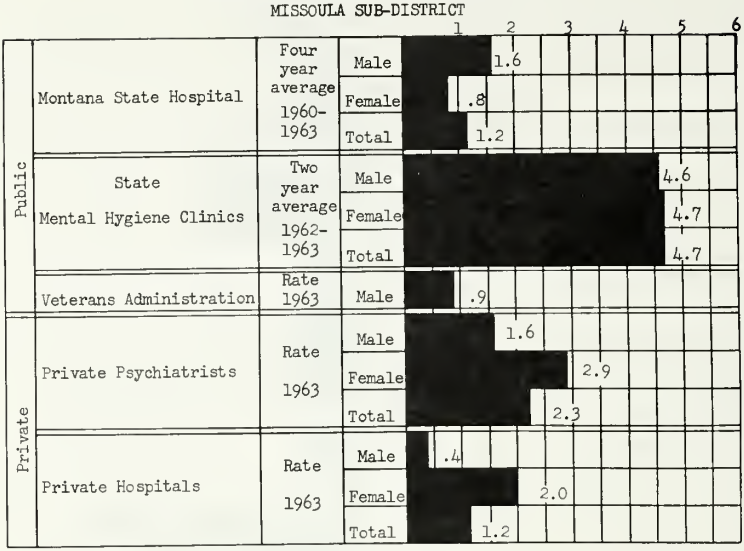

FORM C

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
KALISPELL SUB-DISTRICT



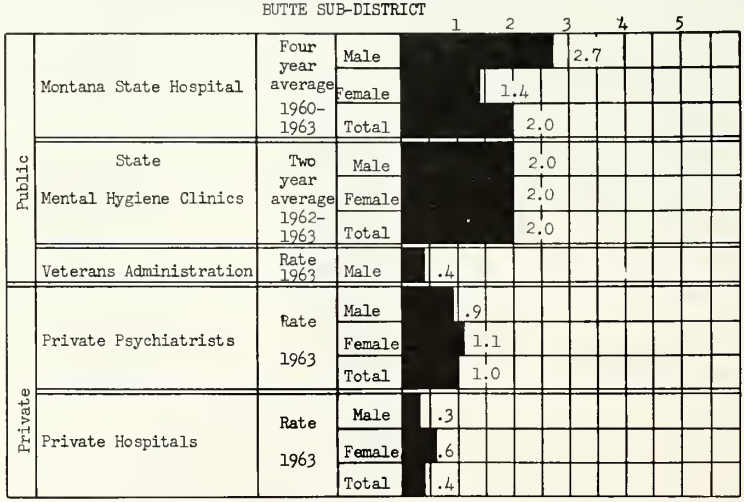
FORM C

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
MISSOULA SUB-DISTRICT




FORM C

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
BUTTE SUB-DISTRICT



REVIEW OF COMMUNITY MENTAL HEALTH RESOURCES
FORM D
AS OF JANUARY 1, 1965

| | District | | Sub-District | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Missoula | | Kalispell | | Missoula | | Butte | |
| | Number | Estimated Capacity | Number | Estimated Capacity | Number | Estimated Capacity | Number | Estimated Capacity |
| Psychiatric Facilities: | | | | | | | | |
| State Mental Hospitals | 1 | 1467 | - | - | - | - | 1 | 1467 |
| General hospitals with psychiatric services | 1 | 6 | - | - | 1 | 6 | - | - |
| Residential treatment centers for emotionally disturbed children | - | - | - | - | - | - | - | - |
| Institutions for the mentally retarded | - | - | - | - | - | - | - | - |
| Outpatient psychiatric state clinics | 2 | - | - | - | 1 | - | 1 | - |
| Private psychiatrists | 2 | - | 1 | - | 1 | - | - | - |
| Transitional services | - | - | - | - | - | - | - | - |
| Other Mental Health Facilities: | | | | | | | | |
| Day-Night units | - | - | - | - | - | - | - | - |
| Half-way houses | - | - | - | - | - | - | - | - |
| Alcoholism clinics | - | - | - | - | - | - | - | - |
| Narcotics clinics | - | - | - | - | - | - | - | - |
| Psychological clinics | - | - | - | - | - | - | - | - |
| Family service agencies | - | - | - | - | - | - | - | - |
| Special psychological services in school systems | - | - | - | - | - | - | - | - |
| Marital counseling centers | - | - | - | - | - | - | - | - |
| Rehabilitation services for the mentally ill | - | - | - | - | - | - | - | - |
| Auxiliary Facilities: | | | | | | | | |
| Sheltered workshops | - | - | - | - | - | - | - | - |
| Nursing homes | 19 | 606 | 6 | 93 | 9 | 368 | 4 | 145 |
| Personal care homes | 10 | 162 | 4 | 67 | 6 | 95 | - | - |
| Chronic disease hospitals | 1 | 92 | - | - | - | - | 1 | 92 |
| Manpower: | | | | | | | | |
| Psychiatrists | 8 | | 1 | | 2 | | 5 | |
| Psychiatric residents | - | | - | | - | | - | |
| Psychologists | 2 | | - | | 1 | | 1 | |
| Social workers | 7 | | - | | 2 | | 5 | |
| Mental health nurses | 27 | | 1 | | - | | 26 | |
| Psychiatric aides | 318 | | - | | - | | 318 | |

SECTION II.

GREAT FALLS COMPREHENSIVE MENTAL HEALTH CENTER DISTRICT
AND CLINIC SUB-DISTRICTS

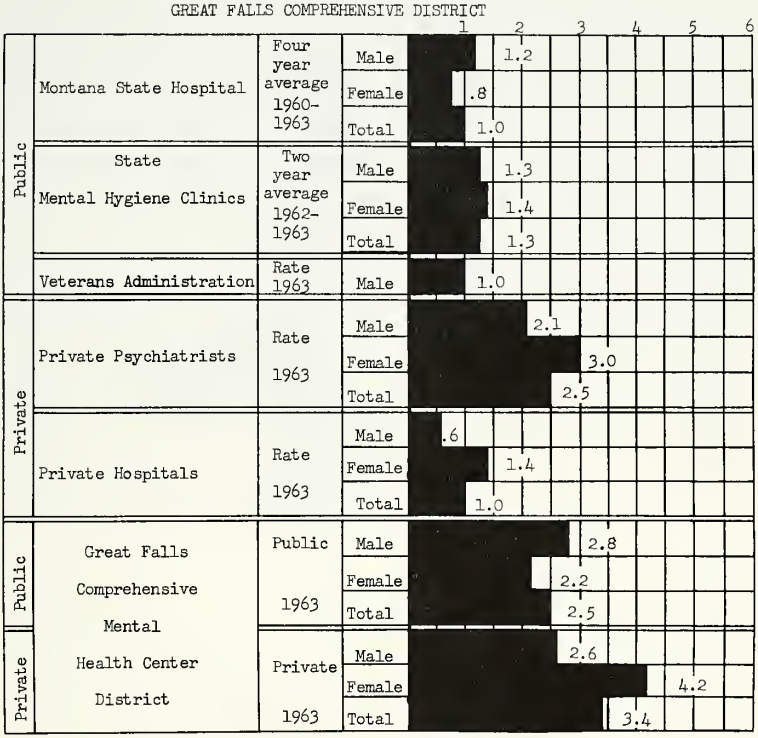
FORM A

INDEXES RELATED TO NEED

| PREVENTION | AVERAGE DISTRICT SCORE | MENTAL HYGIENE DISTRICT WEIGHTED SCORE | | |
|---|---|---|---|---|
| | GREAT FALLS | HELENA | GREAT FALLS | GLASGOW |
| A. Stress Associated With Rapid Urbanization | 55.94 | 54.80 | 58.55 | 49.18 |
| B. Need for Prevention and Rehabilitation Services for Children | 51.42 | 43.91 | 52.09 | 55.62 |
| C. Crime of Violence | 49.27 | 48.38 | 50.35 | 46.79 |
| D. Disrupted Marriage Ratio | 48.84 | 56.48 | 47.83 | 46.30 |
| E. Economic Disequilibrium | 48.75 | 45.04 | 48.35 | 52.59 |
| F. Use of Correctional Facilities | 53.83 | 56.97 | 52.02 | 56.87 |
| AVERAGE | 51.34 | 50.93 | 51.53 | 51.23 |
| TREATMENT AND REHABILITATION | | | | |
| A. Distance to Treatment Resource | 48.34 | 37.54 | 46.29 | 62.06 |
| B. Old Established Population in an Old Established Community | 51.98 | 49.85 | 52.29 | 52.59 |
| C. Stress Associated With Rapid Urbanization | 55.94 | 54.80 | 58.55 | 49.18 |
| D. Alcohol | 56.96 | 63.84 | 57.13 | 51.56 |
| E. Admission Rate - Montana State Hospital | 48.98 | 53.47 | 46.08 | 54.20 |
| F. Admission Rate - Mental Hygiene Clinics | 53.67 | 79.87 | 50.65 | 43.65 |
| G. Financial Assistance Program | 52.06 | 45.08 | 53.24 | 53.65 |
| AVERAGE | 52.56 | 54.92 | 52.03 | 52.41 |
| OVERALL AVERAGE | 52.00 | 53.08 | 51.80 | 51.86 |

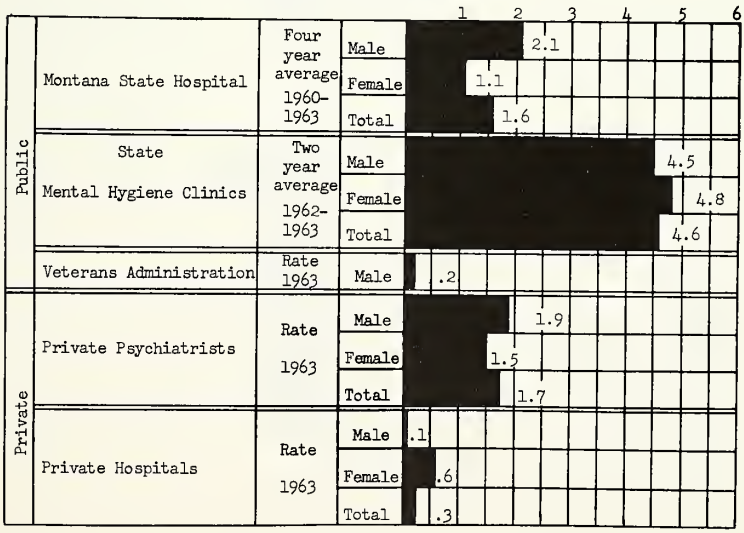
FORM B

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
GREAT FALLS COMPREHENSIVE DISTRICT



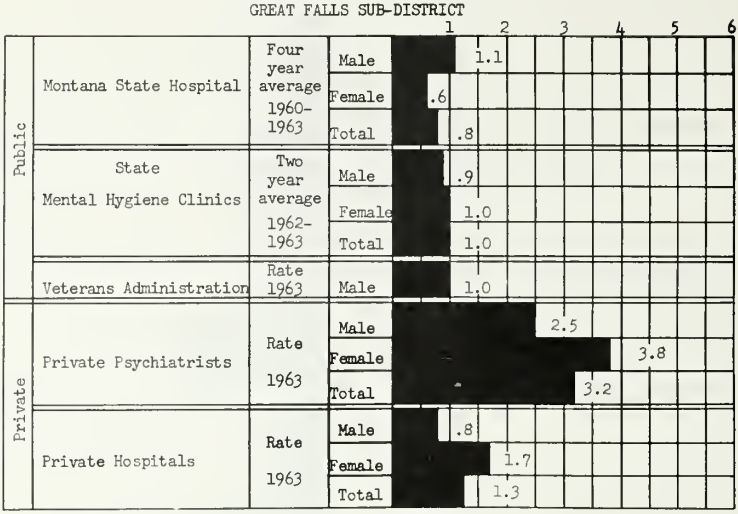

FORM C

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
HELENA SUB-DISTRICT



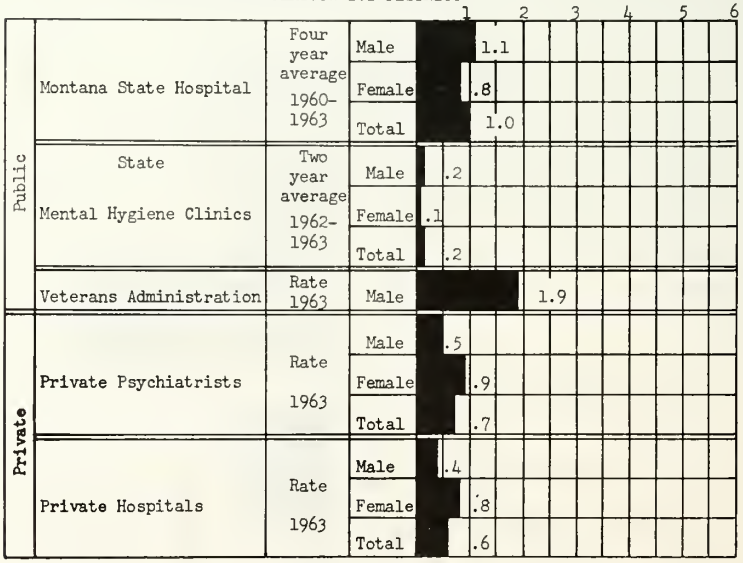
FORM C

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
GREAT FALLS SUB-DISTRICT




FORM C

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
GLASGOW SUB-DISTRICT



REVIEW OF COMMUNITY MENTAL HEALTH RESOURCES
FORM D

AS OF JANUARY 1, 1965

| | District | | Sub-District | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Great Falls | | Helena | | Great Falls | | Glasgow | |
| | Number | Estimated Capacity | Number | Estimated Capacity | Number | Estimated Capacity | Number | Estimated Capacity |
| Psychiatric Facilities: | | | | | | | | |
| State Mental Hospitals | - | - | - | - | - | - | - | - |
| General hospitals with psychiatric services | 1 | 34 | - | - | 1 | 34 | - | - |
| Residential treatment centers for emotionally disturbed children | - | - | - | - | - | - | - | - |
| Institutions for the mentally retarded | 1 | 850 | 1 | 850 | - | - | - | - |
| Outpatient psychiatric state clinics | 2 | - | 1 | - | 1 | - | - | - |
| Private psychiatrists | 4 | - | - | - | 4 | - | - | - |
| Transitional services | - | - | - | - | - | - | - | - |
| Other Mental Health Facilities: | | | | | | | | |
| Day-Night units | - | - | - | - | - | - | - | - |
| Half-way houses | - | - | - | - | - | - | - | - |
| Alcoholism clinics | - | - | - | - | - | - | - | - |
| Narcotics clinics | - | - | - | - | - | - | - | - |
| Psychological clinics | - | - | - | - | - | - | - | - |
| Family service agencies | - | - | - | - | - | - | - | - |
| Special psychological services in school systems | 1 | - | 1 | - | - | - | - | - |
| Marital counseling centers | 1 | - | 1 | - | - | - | - | - |
| Rehabilitation services for the mentally ill | - | - | - | - | - | - | - | - |
| Auxiliary Facilities: | | | | | | | | |
| Sheltered workshops | - | - | - | - | - | - | - | - |
| Nursing homes | 17 | 507 | 3 | 48 | 12 | 381 | 2 | 78 |
| Personal care homes | 16 | 344 | 4 | 137 | 9 | 147 | 3 | 60 |
| Chronic disease hospitals | 1 | 132 | - | - | 1 | 132 | - | - |
| Manpower: | | | | | | | | |
| Psychiatrists | 5 | | 1 | | 4 | | - | |
| Psychiatric residents | - | | - | | - | | - | |
| Psychologists | 2 | | 1 | | 1 | | - | |
| Social workers | 2 | | - | | 2 | | - | |
| Mental health nurses | 7½ | | - | | 7½ | | - | |
| Psychiatric aides | 10 | | - | | 10 | | - | |

SECTION III.
BILLINGS COMPREHENSIVE MENTAL HEALTH CENTER DISTRICT
AND CLINIC SUB-DISTRICTS

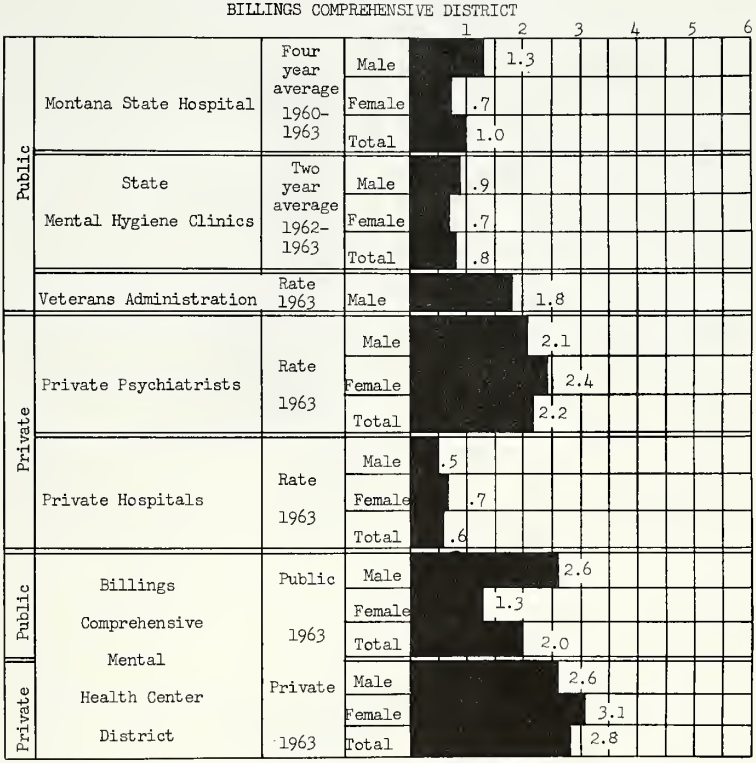
FORM A

INDEXES RELATED TO NEED

| PREVENTION | AVERAGE DISTRICT SCORE | MENTAL HYGIENE DISTRICT WEIGHTED SCORE | | |
|---|---|---|---|---|
| | BILLINGS | BOZEMAN | BILLINGS | MILES CITY |
| A. Stress Associated With Rapid Urbanization | 57.46 | 53.15 | 62.69 | 50.31 |
| B. Need for Prevention and Rehabilitation Services for Children | 48.81 | 41.41 | 49.82 | 52.32 |
| C. Crime of Violence | 48.51 | 46.93 | 50.11 | 46.52 |
| D. Disrupted Marriage Ratio | 44.51 | 45.09 | 44.49 | 44.12 |
| E. Economic Disequilibrium | 46.97 | 44.25 | 44.68 | 50.25 |
| F. Use of Correctional Facilities | 50.80 | 46.21 | 52.13 | 51.57 |
| AVERAGE | 49.51 | 46.17 | 50.65 | 49.18 |
| TREATMENT AND REHABILITATION | | | | |
| A. Distance to Treatment Resource | 51.27 | 39.96 | 49.89 | 62.43 |
| B. Old Established Population in an Old Established Community | 50.95 | 51.74 | 51.03 | 50.19 |
| C. Stress Associated With Rapid Urbanization | 57.46 | 53.15 | 62.69 | 50.31 |
| D. Alcohol | 50.48 | 49.48 | 53.08 | 46.06 |
| E. Admission Rate - Montana State Hospital | 51.35 | 49.13 | 52.85 | 50.05 |
| F. Admission Rate - Mental Hygiene Clinics | 48.84 | 45.48 | 52.05 | 44.96 |
| G. Financial Assistance Program | 49.24 | 45.68 | 52.14 | 46.13 |
| AVERAGE | 51.37 | 47.80 | 53.39 | 50.02 |
| OVERALL AVERAGE | 50.51 | 47.05 | 52.13 | 49.63 |

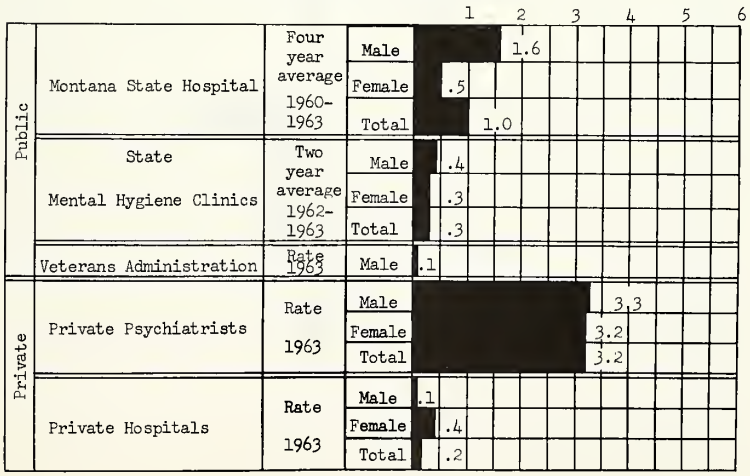
FORM B

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
BILLINGS COMPREHENSIVE DISTRICT



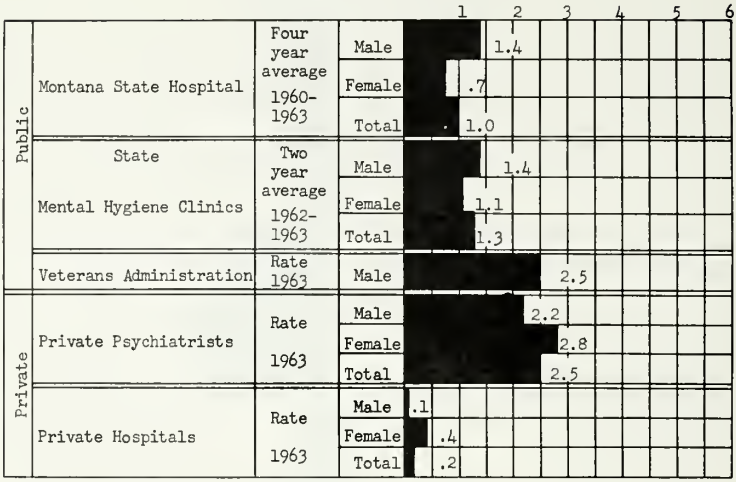

FORM C

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
BOZEMAN SUB-DISTRICT



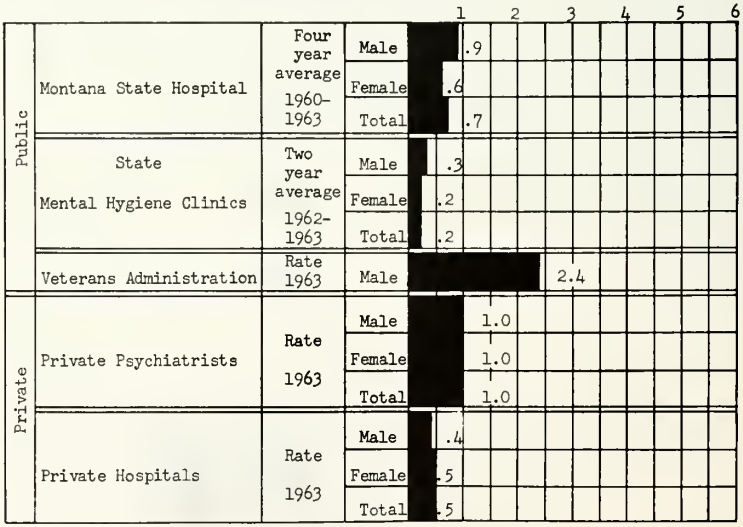
FORM C

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
BILLINGS SUB-DISTRICT




FORM C

FIRST ADMISSION AGE-SEX SPECIFIC RATES
PER 1,000 MONTANA POPULATION
REPORTED BY PUBLIC AND PRIVATE RESOURCES
MILES CITY SUB-DISTRICT



REVIEW OF COMMUNITY MENTAL HEALTH RESOURCES

FORM D

AS OF JANUARY 1, 1965

| | District | | Sub-District | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Billings | | Bozeman | | Billings | | Miles City | |
| | Number | Estimated Capacity | Number | Estimated Capacity | Number | Estimated Capacity | Number | Estimated Capacity |
| Psychiatric Facilities: | | | | | | | | |
| State Mental Hospitals | - | - | - | - | - | - | - | - |
| General hospitals with psychiatric services | 1 | 8 | - | - | 1 | 8 | - | - |
| Residential treatment centers for emotionally disturbed children | - | - | - | - | - | - | - | - |
| Institutions for the mentally retarded | - | - | - | - | - | - | - | - |
| Outpatient psychiatric state clinics | 1 | - | - | - | 1 | - | - | - |
| Private psychiatrists | 7 | - | 1 | - | 5 | - | 1 | - |
| Transitional services | - | - | - | - | - | - | - | - |
| Other Mental Health Facilities: | | | | | | | | |
| Day-Night units | - | - | - | - | - | - | - | - |
| Half-way houses | - | - | - | - | - | - | - | - |
| Alcoholism clinics | - | - | - | - | - | - | - | - |
| Narcotics clinics | - | - | - | - | - | - | - | - |
| Psychological clinics | - | - | - | - | - | - | - | - |
| Family service agencies | - | - | - | - | - | - | - | - |
| Special psychological services in school systems | 2 | - | 1[1] | - | - | - | 1[2] | - |
| Marital counseling centers | - | - | - | - | - | - | - | - |
| Rehabilitation services for the mentally ill | - | - | - | - | - | - | - | - |
| Auxiliary Facilities: | | | | | | | | |
| Sheltered workshops | - | - | - | - | - | - | - | - |
| Nursing homes | 20 | 656 | 7 | 145 | 6 | 289 | 7 | 222 |
| Personal care homes | 20 | 249 | 4 | 55 | 12 | 142 | 4 | 52 |
| Chronic disease hospitals | 1 | 32 | - | - | 1 | 32 | - | - |
| Manpower: | | | | | | | | |
| Psychiatrists | 8 | | 1 | | 6 | | 1 | |
| Psychiatric residents | - | | - | | - | | - | |
| Psychologists | 1 | | - | | 1 | | - | |
| Social workers | 1 | | - | | 1 | | - | |
| Mental health nurses | 3 | | - | | 3 | | - | |
| Psychiatric aides | 7½ | | - | | 7½ | | - | |

1 - Montana State College, Bozeman, Student Health Center

2 - Montana State Industrial School, Miles City

were considered professionals of that discipline. For example, anyone employed as a social worker would be counted as a social worker whether or not that person holds a graduate degree in social work.

## MENTAL HEALTH COMPREHENSIVE DISTRICTS

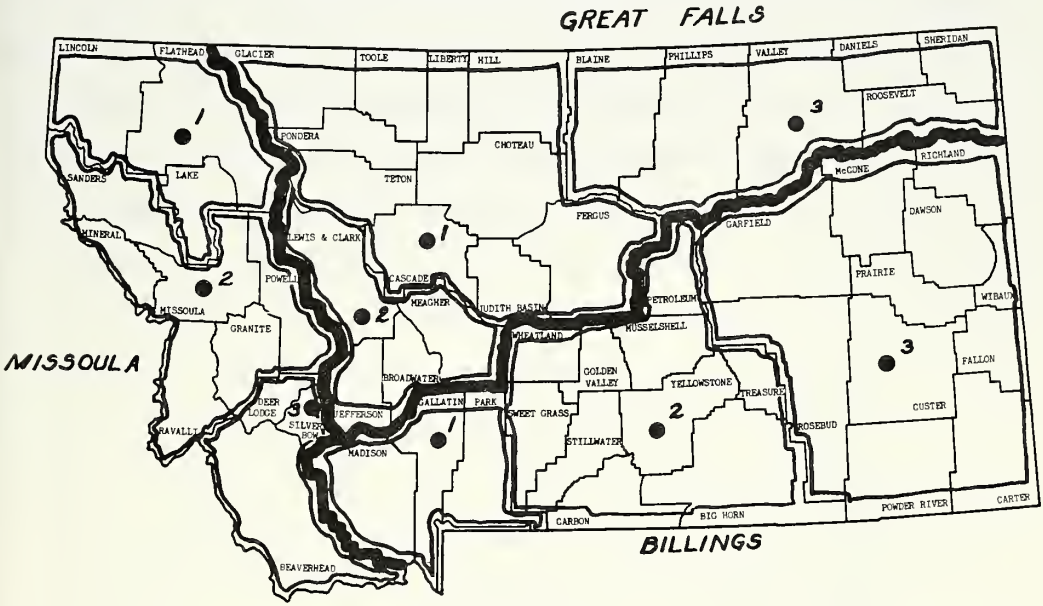
The concept of dividing Montana into the three noted districts, (see Map 9.1), with selected cities as possible sites for comprehensive mental health centers, evolved after considerable effort from both statistical and less objective evaluatory methods was expended. It might appear from cursory examination that three districts, for a geographical area as large as Montana, are not nearly enough. However, when considered in the light of other delimiting factors, e.g., population served, transportation, service areas, etc., these districts as delineated are, in the opinion of the Planning Committee, the most practical that can be presented at this time. Any plan that is to be truly "comprehensive" for Montana must be cognizant of the problems of the state's rural population as well as the urban. In the opinion of the Planning Committee, these districts as outlined consider the needs of Montana and her people as well as can be done for the present and for the predictable future.

## DISTRICT AREAS

Presently, the thinking of most astute planners in the problems of mental health involves a central concept of providing treatment, early and as near to the patients' home as practicable. In line with this central theme, a comprehensive center should be situated at a location that could afford to its catchment area these two basic tenets of

MAP 9.1

AREA DELINEATION FOR
MENTAL HYGIENE CLINICS AND
COMMUNITY COMPREHENSIVE MENTAL HEALTH DISTRICTS




——— = Delineation areas for clinics

▬▬▬ = Delineation areas for community comprehensive mental health center districts

COMMUNITY COMPREHENSIVE MENTAL HEALTH CENTER DISTRICTS

| | | |
|---|---|---|
| A. MISSOULA - 207,831 | B. GREAT FALLS - 244,428 | C. BILLINGS - 222,461 |
| 1. Kalispell - 58,606 | 1. Great Falls - 153,563 | 1. Bozeman - 44,424 |
| 2. Missoula - 76,937 | 2. Helena - 37,723 | 2. Billings - 117,512 |
| 3. Butte - 72,288 | 3. Glasgow - 53,142 | 3. Miles City - 60,525 |

TOTAL - 674,720

treatment. The establishment of comprehensive community mental health centers would be a step in the direction of community based treatment. Three such centers are proposed for eventual development in Montana. The district center cities and their catchment areas are shown on Map 9.1.

The concept of isolating the patient in an institution that is located miles away from any urbanization is in reality the "foreign" procedure to our society. The underlying tenet of any successful service is that it must be provided so as to be accessible to its clientele. Service to our mentally ill should follow this more natural form. This situation is well described in the following quote:[1]

> We must not forget that our present system of large institutions was the first crude effort to escape intolerable medieval conditions and exploitations by city and county politicians, at a time when no trained psychiatrists could be found and no standards were established. Today, the problem takes a more natural form. Small hospitals for definite districts and possibilities of organizing hospital and colony, general hospitals and dispensaries, and civic and social work of a manageable district constitute a practical and manageable method.

Within each district catchment area, three mental hygiene clinic districts have been delineated. National mental health authorities have recommended that full-time mental health clinics be available to each 50,000 population.[2] Montana's large geographical area extends to

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[1] Adolf Meyer, Casework in Social Service and Medical and Social Cooperation in Nervous and Mental Disease (Boston, Massachusetts: National Conference of Charities and Corrections, June 1911), Proceedings of the Conference, p. 77.

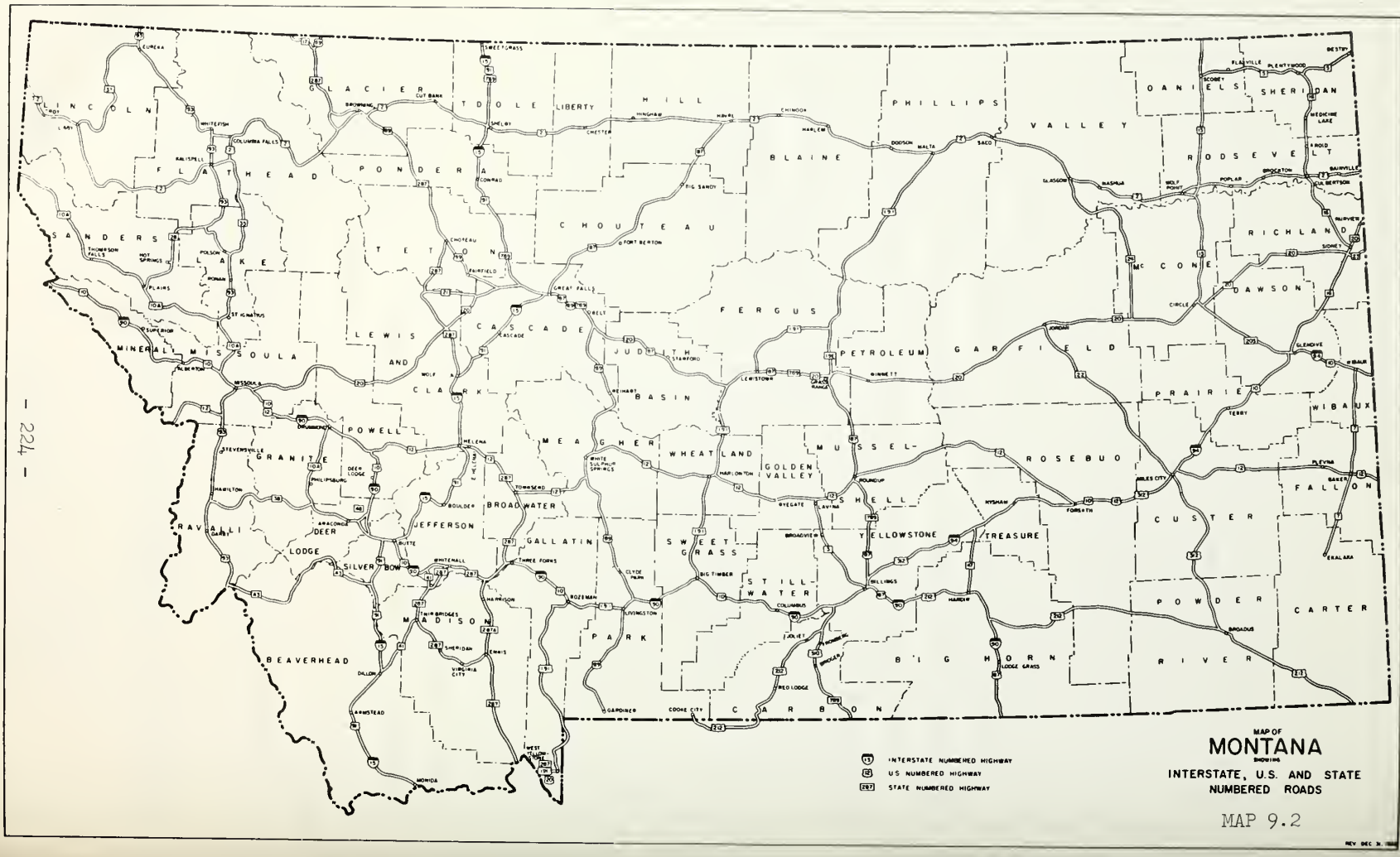
[2] Joint Commission on Mental Illness and Health, Action for Mental Health, (New York: Basic Books, Inc., 1961), p. xiv.

undesirable lengths the distances which must be traveled to obtain services within a catchment area. To help minimize distance within service areas, in at least the realm of outpatient treatment, it is recommended that each comprehensive mental health district have within its bounds the respective sub-districts as shown on Map 9.1 in which it is proposed that there be established mental hygiene clinics. The rationale for selection of the proposed district area boundaries was based on topographical characteristics, transportation patterns, distance of travel, highway routes, service areas, population and political subdivision boundaries.

Topographical characteristics of Montana do not present insurmountable problems in establishing comprehensive mental health districts. A statement covering Montana's topography is found on Page 16 of this report.

Transportation patterns have extreme importance in Montana because of the largeness of the state and the consequent long distances that people must travel to receive services. Map 9.2 shows that no county is without a primary road to and from the county seat. The state's highways have been steadily improved over the past 10 years; federal aid has been eminent in this development. Roads are maintained all year with the several passes through which inter-state highway systems traverse remaining open to traffic during all months of the year. The Montana Highway Maintenance Division reports that it is responsible for 11,904 miles of primary and secondary roads.[1] With the development of new road

[1]As of telephone conversation with State of Montana Highway Department Maintenance Section, March 29, 1965.




MAP OF
# MONTANA
SHOWING
INTERSTATE, U.S. AND STATE
NUMBERED ROADS

MAP 9.2

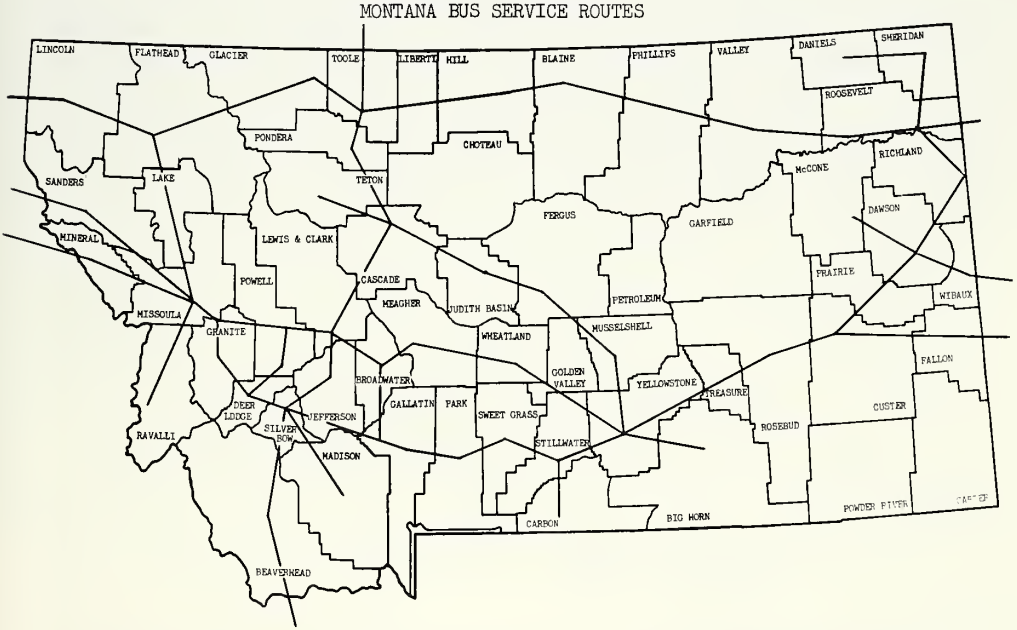
REV. DEC. 3.

systems, it is likely that patterns of transportation will change as well as the catchment area of service centers. These factors may result in a necessity to modify the presently existent mental health programs.

Present bus routes are indicated on Map 9.3.[1]

MAP 9.3

MONTANA BUS SERVICE ROUTES




Several areas have no bus service and resident individuals must depend on personal transporation , friends and neighbors for travel to distant points. From the standpoint of distance, the three counties located in the extreme northeastern corner of Montana -- Daniels, Sheridan, and Roosevelt -- are the furthest from any source of mental health assistance. Bus service from these three counties is faster and more convenient to Great Falls than to Billings. In many areas of the state there is only limited bus service, further necessitating the need to develop mental

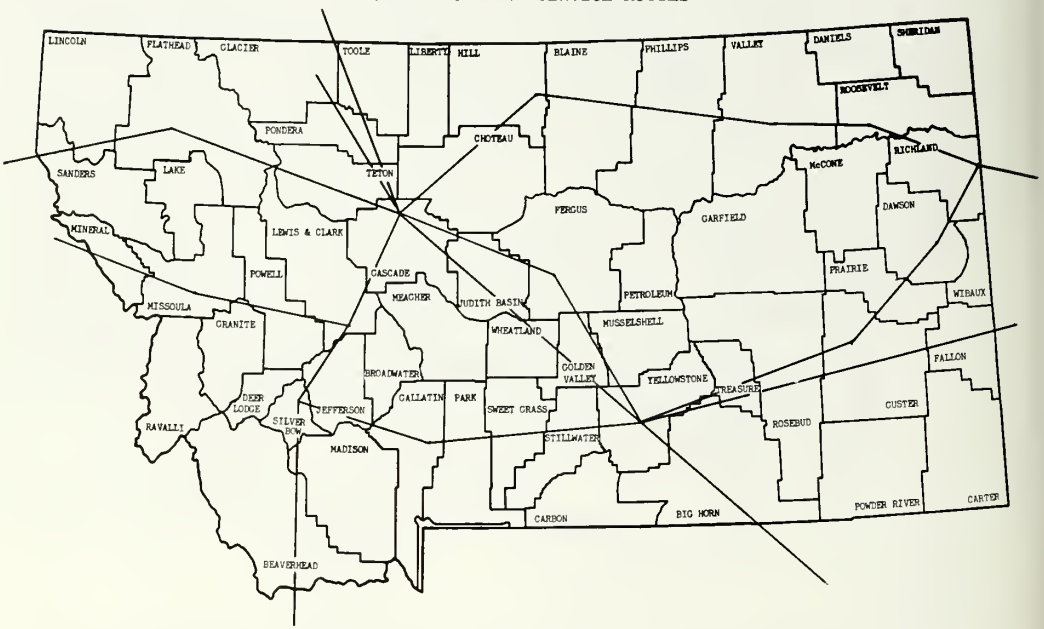
[1]Routes are shown as of February 1965.

health programming that will meet the needs of the individuals living in these remote areas.

Map 9.4 indicates the routes along which air travel is provided in Montana.

MAP 9.4

MONTANA AIRLINE SERVICE ROUTES

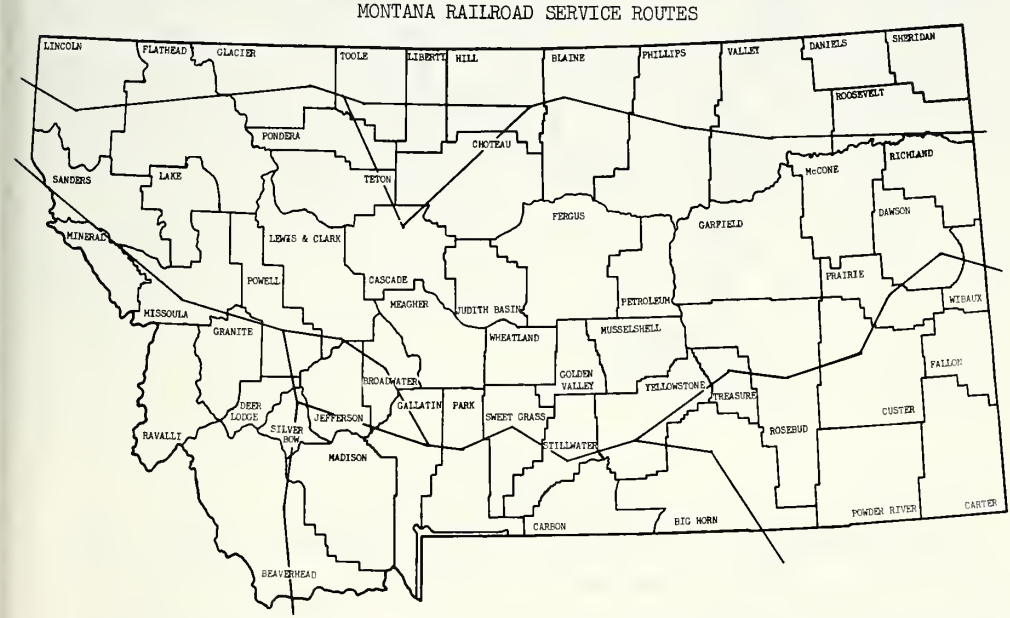



It is evident that air service is being provided to all the more populated areas of the state. Air transport of traveling psychiatric teams to sub-districts from the comprehensive district centers should be considered as a service alternative. Air travel has many advantages over travel by some means of ground transit. The most significant advantage would be in the saving of time of the professionals involved, thus allowing more time for actual treatment. In a state operation, air travel cost is about the same as ground travel when all factors are considered. (See Map 9.4 for air routes)

Railroads provide passenger transportation, but as can be seen from the route map, (Map 9.5), most of the travel pattern is in an east-west direction. Scheduling is problematical and would be disadvantageous to the user from the standpoint of time lost.

MAP 9.5

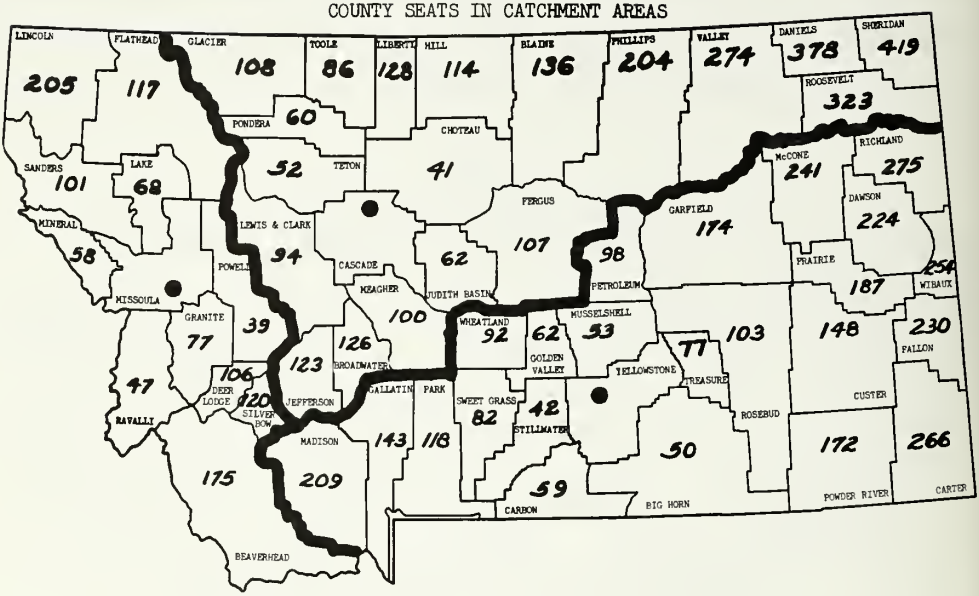
MONTANA RAILROAD SERVICE ROUTES




Distance in Montana generally presents many problems, particularly those of time and cost. However, the resident of Montana has grown accustomed to traveling for services and 200 miles or more to travel is not considered to be prohibitive. The distances from county seats to the comprehensive mental health centers and to mental hygiene clinics have been shown on Map 9.6 and Map 9.7. The districts were carefully analyzed from several criteria in addition to those already mentioned, including present usage of public and private mental health facilities

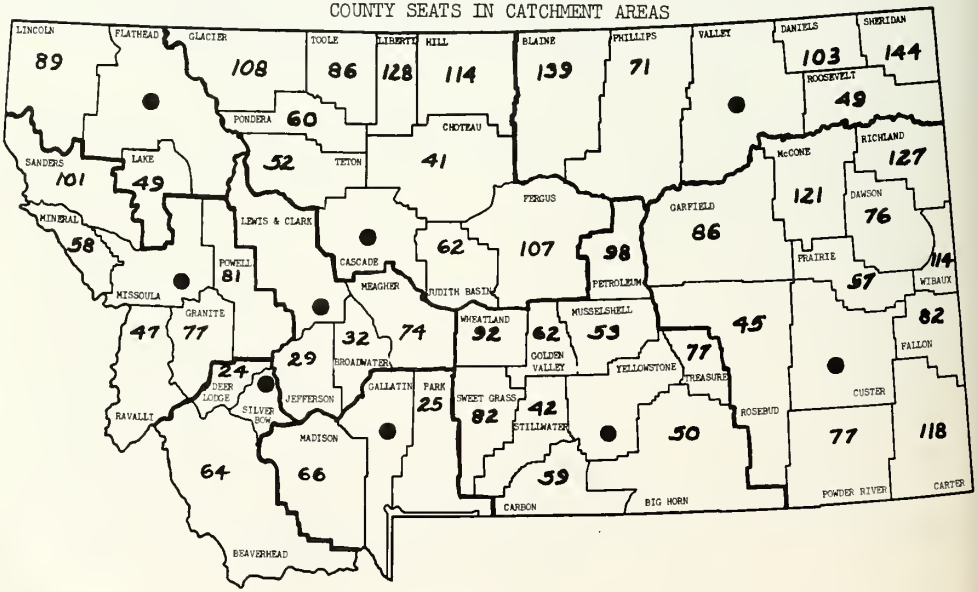
MAP 9.6

ROAD DISTANCES
TO COMPREHENSIVE CENTERS
FROM
COUNTY SEATS IN CATCHMENT AREAS




MAP 9.7

ROAD DISTANCES
TO MENTAL HYGIENE CLINICS
FROM
COUNTY SEATS IN CATCHMENT AREAS



and local survey questionnaires. This combined data was utilized in the establishment of boundaries for the service areas.

Utilizing the estimated population data as compiled by the Board of Health, Vital Statistics Division, the populations of the districts that will serve as mental hygiene clinic districts and as comprehensive districts can be estimated. These are indicated in Table 9.1.

The limitations involved in making population projections should be kept in mind. The Bureau of the Census at the request of the National Education Association prepared the following unofficial population figures for Montana projected to the year 1970: for 1965--724,000; for 1970--779,000.[1] The Outdoor Recreation Resources Review Commission Study, report No. 23, estimated that in 1976 Montana population will be 887,000. This same source estimates that by the year 2000 Montana's population will be 1,351,000.[2]

It appears unnecessary to further establish need, as it is most evident that need for services in all of the comprehensive districts exceeds services available. This need is evidenced in the data presented in the preceding pages. The problem which arises now is to make determinations with regard to the relative need of the districts. Because the Missoula comprehensive district has within its confines the state mental hospital, and thus essentially has services which are more

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[1]Western Interstate Commission for Higher Education, Resource Book of Western Population Data (Portland, Oregon: Western Interstate Commission for Higher Education, February 16-19), p. 2.

[2]Outdoor Recreation Resources Review Commission, Projections to the Years 1976 and 2000. . . . . (Denver, Colorado: Outdoor Recreation Review Commission), ORRRC Study Report 23, pp. 42, 416.

TABLE 9.1

PROJECTED POPULATIONS FOR MONTANA
BY COMPREHENSIVE AND MENTAL HYGIENE DISTRICTS

| DISTRICT | YEARS | | | |
|---|---|---|---|---|
| | 1960[1] | 1961[2] | 1962[2] | 1963[2] |
| Comprehensive Districts | | | | |
| A. Missoula | 207,831 | 208,000 | 215,000 | 214,000 |
| B. Great Falls | 244,428 | 251,200 | 263,200 | 263,600 |
| C. Billings | 222,461 | 222,800 | 230,800 | 229,400 |
| Mental Hygiene Clinic Districts | | | | |
| A. 1. Kalispell | 58,606 | 58,900 | 61,100 | 61,100 |
| 2. Missoula | 76,937 | 77,100 | 79,900 | 79,500 |
| 3. Butte | 72,288 | 72,000 | 74,000 | 73,400 |
| B. 1. Helena | 37,723 | 38,100 | 39,800 | 39,600 |
| 2. Great Falls | 153,563 | 157,300 | 164,700 | 164,700 |
| 3. Glasgow | 53,142 | 55,800 | 58,700 | 59,300 |
| C. 1. Bozeman | 44,424 | 44,600 | 45,900 | 45,200 |
| 2. Billings | 117,512 | 117,600 | 121,400 | 120,800 |
| 3. Miles City | 60,525 | 60,600 | 63,500 | 63,400 |
| | | | | |

[1]U.S., Bureau of Census, U.S. Census of Population: 1960, General Population Characteristics, Montana, Final Report PC (1)-28B, p. 28-23.

[2]Montana State Board of Health, Division of Records and Statistics, Population Estimates Montana Counties, July 1, 1961, 1962, 1963.

accessible to its populace than these same services are to either of the other two comprehensive districts, the Planning Committee expressed the opinion that both the Great Falls and the Billings comprehensive districts should have priority over the Missoula district with respect to construction of a comprehensive community health center.

After thus delineating the priority districts, it becomes evident that a further delineation should be made to establish one of two remaining comprehensive districts as No. 1. It was apparent early in the planning process that objectivity becomes difficult to maintain at every level of planning. A level particularly susceptive to subjectivity is the area involving determination of priority. In an effort to maintain objectivity, the variables explained in the preceding pages were selected and utilized. In addition, extensive care was exercised in the comparison of the districts, one to the other, with respect to any additional determinants that were judged to have bearing on the assignment of a priority to the districts.

If the weighted scores as reported are to be significant in swaying the decision of priority, there should be expressed in the score of the district of choice a substantially higher index of need than that found in its comparative. It is interesting to note that when the scores are thus considered, neither district emerges with an index expressive of anything unique. Since the scores do not show any suggestive variation, their utilization becomes rather meaningless to an attempt to resolve priority.

The additional determinants likewise pointed up a very close correlation between the two districts under consideration. In the sources

of private treatment there is some variation. Great Falls district, with more people, (see Map 9.1), has only half as many psychiatrists, yet four times as many private psychiatric hospital beds as the Billings district. When nursing home and personal care home beds are considered, it is found that Great Falls district has 3.5 beds for every thousand people, and Billings district, 4.1 beds for every thousand. According to an estimate by the State Construction Authority for Hospital and Medical Facilities, these services fulfill about 70 percent of the need in Great Falls for nursing home type beds, and about 82 percent of the need in Billings.

The Billings district serves the largest area in square miles; however, it is not significantly larger than the Great Falls district. Billings district has four more counties to serve, but approximately 22,000 less people. See Table 9.2 below.

TABLE 9.2

COMMUNITY COMPREHENSIVE DISTRICTS
SHOWING
POPULATION, SQUARE MILES AND NUMBER OF COUNTIES IN EACH

| COMPREHENSIVE DISTRICT | POPULATION | SQUARE MILES | NUMBER COUNTIES |
|---|---|---|---|
| Missoula | 207,831 | 30,831 | 12 |
| Great Falls | 244,428 | 55,082 | 20 |
| Billings | 222,461 | 61,225 | 24 |
| State | 674,720 | 147,138 | 56 |

If we consider that a single mental hygiene clinic can effectively only serve 50,000 people, there should be at a minimum of three additional clinics to those already existing in both the Billings and Great Falls comprehensive mental health districts. However, due to Montana's

population pattern, it is recommended that for the immediate future at least, only a total of three in each district be established, located as shown on Map 9.1.

In the final analysis it would appear that objective data does not point significantly to either Great Falls or Billings as the first site for a comprehensive center to be constructed. It is the opinion of the Planning Committee that less objective factors involving community support - e.g., willingness of the communities medical specialties to actively cooperate as consultants and therapists; willingness of local hospitals to affiliate with the center in providing necessary ancillary services - will provide very important bases for priority decisions. Both districts suffer from much the same malady: too limited facility and personnel to serve too large an area in both land and population.

Before a site for the first community comprehensive mental health center is finally selected and construction begun, the moot question remains: "Where in Montana can this center be most effectively situated and operated?" Ranking the districts as to relative need will be a function of the State Board of Health because this agency has been designated by the Governor to administer the construction plan. It is hoped that careful consideration will be given to both the Great Falls and Billings districts and that a final determination will be based on the data herein available and whatever additional judgmental information that may become available.

CHAPTER X

## FINANCIAL ASPECTS OF THE MENTAL HEALTH PROGRAM

Historically, the responsibility and care of the mentally ill has rested with the public hospitals. It has been estimated that 90 percent of all hospitalized mental patients are in public hospitals. Presumably, the remainder of all mental patients are cared for in private and voluntary hospitals.

Financing the care of the mentally ill has principally been carried by state funds.[1]

> The total maintenance expenditure for patients in public mental hospitals, excluding capital expenditures but including maintenance in county hospitals, has grown from approximately 662 million in 1956 to almost 1,085 million in 1963. This represents a growth in average daily patient cost from $3.26 to $5.81.

Montana experienced a similar growth in average daily patient cost from $3.07 in fiscal 1956 to $5.54 for fiscal year 1964.[2] Table 10.1 shows the average daily maintenance expenditures per resident patient in public mental hospitals by state for the years 1956, 1958, 1960 and 1962.

It is recognized that a precise comparable method of computing the average daily patient cost is not found in common among the states - let alone one that is adhered to by Montana and the states contiguous to it. In making cost comparisons between states, this aforementioned fact makes it evident that these comparisons lack complete accuracy. The cost

[1] Emory Ferebee, Ph.D., Financing of Community Mental Health Services, paper read at the University of Indiana, 1964.

[2] U.S., Department of Health, Education and Welfare, Public Health Service, National Institute of Mental Health, Mental Health Statistics Current Reports, (Bethesda, Maryland: National Clearinghouse for Mental Health Information, January 1965), Series MHB-H-9, p. 8.

TABLE 10.1

AVERAGE DAILY MAINTENANCE EXPENDITURE PER RESIDENT PATIENT, PUBLIC MENTAL HOSPITALS [1]

| STATE | 1956 | 1958 | 1960 | 1962 | 1962 Rank | Change in rank 1960-1962 |
|---|---|---|---|---|---|---|
| U.S. average | $3.18 | $4.06 | $4.72 | $5.43 | | |
| U.S. median | 3.17 | 3.93 | 4.76 | 5.51 | | |
| Alabama | 2.13 | 2.46 | 2.75 | 3.31 | 47 | 0 |
| Alaska | N.A. | N.A. | 8.31 | 14.14 | 1 | 0 |
| Arizona | 3.61 | 4.24 | 5.00 | 5.62 | 23 | 0 |
| Arkansas | 2.60 | 3.37 | 3.53 | 3.85 | 44 | -2 |
| California | 3.80 | 5.08 | 5.51 | 7.17 | 6 | +7 |
| Colorado | 3.78 | 4.72 | 5.00 | 7.25 | 5 | +17 |
| Connecticut | 4.73 | 5.80 | 6.28 | 6.96 | 9 | -5 |
| Delaware | 4.08 | 4.72 | 5.06 | 6.21 | 15 | +4 |
| District of Columbia | 5.51 | 6.17 | 7.23 | 8.89 | 3 | 0 |
| Florida | 2.54 | 3.29 | 3.77 | 4.36 | 40 | -2 |
| Georgia | 2.73 | 2.62 | 2.53 | 3.00 | 49.5 | - .5 |
| Hawaii | 3.76 | 4.56 | 5.66 | 6.31 | 13 | -3 |
| Idaho | 3.17 | 4.47 | 5.78 | 6.37 | 12 | -4 |
| Illinois | 2.95 | 3.66 | 4.53 | 5.06 | 32 | -1 |
| Indiana | 3.83 | 4.45 | 5.02 | 5.45 | 29 | -9 |
| Iowa | 3.64 | 4.28 | 5.72 | 8.04 | 4 | +5 |
| Kansas | 4.59 | 6.15 | 7.34 | 9.90 | 2 | 0 |
| Kentucky | 2.07 | 2.99 | 3.58 | 4.97 | 33 | +7 |
| Louisiana | 2.08 | 2.76 | 3.29 | 4.05 | 41.5 | +3.5 |
| Maine | 3.12 | 3.77 | 4.48 | 4.84 | 35 | -3 |
| Maryland | 3.45 | 4.47 | 5.20 | 5.71 | 20 | -3 |
| Massachusetts | 3.82 | 4.80 | 5.29 | 6.80 | 10 | +6 |
| Michigan | 4.33 | 5.11 | 5.58 | 6.03 | 17 | -6 |
| Minnesota | 3.01 | 3.89 | 4.61 | 5.49* | 28 | +2 |
| Mississippi | 2.04 | 2.11 | 2.26 | 2.74 | 51 | 0 |
| Missouri | 2.83 | 3.52 | 3.45 | 4.60 | 39 | +4 |
| Montana | 3.07 | 3.66 | 4.41 | 4.94 | 34 | -1 |
| Nebraska | 3.79 | 4.59 | 5.89 | 6.49 | 11 | -4 |
| Nevada | 3.29 | 4.27 | 4.77 | 5.97 | 18 | +8 |
| New Hampshire | 3.82 | 4.53 | 4.92 | 5.51 | 25.5 | -1.5 |
| New Jersey | 3.88 | 4.94 | 5.14 | 6.16 | 16 | +2 |
| New Mexico | 4.34 | 4.91 | 5.98 | 5.51 | 25.5 | -19.5 |
| New York | 3.44 | 4.28 | 5.58 | 5.53 | 24 | -12 |
| North Carolina | 2.93 | 3.97 | 4.10 | 4.72 | 37 | -1 |
| North Dakota | 2.88 | 3.49 | 4.37 | 4.83 | 36 | -2 |
| Ohio | 3.22 | 4.21 | 4.70 | 5.13* | 31 | -3 |
| Oklahoma | 2.47 | 2.99 | 3.56 | 4.05* | 41.5 | - .5 |
| Oregon | 2.95 | 3.87 | 4.61 | 6.30 | 14 | +15 |
| Pennsylvania | 3.06 | 3.73 | 4.35 | 5.50 | 27 | +8 |
| Rhode Island | 3.27 | 4.41 | 4.74 | 5.78 | 19 | +8 |
| South Carolina | 2.24 | 2.41 | 2.52 | 3.11 | 48 | +2 |
| South Dakota | 3.24 | 3.66 | 3.80 | 4.70 | 38 | -1 |
| Tennessee | 1.84 | 2.45 | 2.72 | 3.43 | 46 | +2 |
| Texas | 2.07 | 3.07 | 3.65 | 4.01 | 43 | -4 |
| Utah | 2.43 | 3.45 | 5.40 | 7.16 | 7 | +8 |
| Vermont | 3.24 | 4.65 | 5.43 | 5.68 | 21 | -7 |
| Virginia | 2.63 | 3.08 | 3.40 | 3.75 | 45 | -1 |
| Washington | 3.10 | 4.28 | 6.12 | 7.08 | 8 | -3 |
| West Virginia | 1.90 | 2.33 | 2.75 | 3.00* | 49.5 | -3.5 |
| Wisconsin | 3.40 | 4.06 | 4.89 | 5.41 | 30 | -5 |
| Wyoming | 3.36 | 3.71 | 5.01 | 5.64 | 22 | -1 |

SOURCE: 1956, 1958, and 1960: FIFTEEN INDICES, Feb., 1962. 1962: Mental Health Statistics, Current Reports, Series MHB-H-7, National Institute of Mental Health, Jan., 1963. Data are provisional.

[1] Includes state and county hospitals.

*Indicates data which are estimates or include estimates.

American Psychiatric Association and the National Association for Mental Health, Fifteen Indices, (Washington, D.C.: The Joint Information Services, February 1964), pp. 14-15.

accounting practices utilized do not employ means whereby the reported figures are adjusted for such additional delimiting criteria as differentials in living costs between states and variations in the patient turnover rate between hospitals.

Statistics show a slow but steady reduction in resident patients in Montana State Hospital from 1956 to 1964.[1] National statistics show a similar decline in the number of resident patients in mental hospitals. This has occurred in spite of increases in the general population. In states where increased legislative appropriations have been made for additional professional mental health personnel, a significant decline in resident patients has taken place.[2] This decline in the number of resident patients in Montana State Hospital between 1955 and 1964 is compared with those from Utah, Idaho, Colorado and Wyoming in Table 10.2.[3]

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[1] Supra, p. 82.

[2] Dr. H. Edward Beaghler, Assistant Superintendent, Utah State Hospital, described the program that lowered the resident patient population of Utah State Hospital by half. Dr. Beaghler's findings are in a conference report on mental health, The Organization of the Hospital for Optimal Patient Care, ed. Jerome Levy and Roma K. McNickle (Boulder, Colorado: Western Interstate Commission for Higher Education, June 1962), pp. 10-14.

[3] U.S., Department of Health, Education and Welfare, Public Health Service, National Institute of Mental Health, Mental Health Statistics Current Reports, (Bethesda, Maryland: National Clearinghouse for Mental Health Information, January 1965), Series MHB-H-9, p. 8.

TABLE 10.2

PERCENTAGE OF INCREASE OR DECREASE IN NUMBER OF PATIENTS RESIDING IN PUBLIC MENTAL HOSPITALS LOCATED IN UTAH, IDAHO, COLORADO, MONTANA AND WYOMING AT END OF YEARS 1955 AND 1964

| STATE | YEAR | | NUMBER[1] FULL-TIME PERSONNEL | INCREASE OR DECREASE 1955-1964 | PER CAPITA COST 1964 | % INCREASE OR DECREASE RESIDENT POPULATION |
|---|---|---|---|---|---|---|
| | 1955[1] | 1964 | | | | |
| Utah | 1337 | 603 | 450 | - 724 | 10.76 | -54.9 |
| Idaho | 1221 | 820 | 451 | - 401 | 8.31 | -32.8 |
| Colorado | 5786 | 3784 | 2690 | -2002 | 11.65 | -34.6 |
| Montana | 1919 | 1541 | 573 | - 378 | 5.54 | -19.7 |
| Wyoming | 655 | 684 | 266 | + 29 | 5.86 | + 4.4 |

[1]National Committee Against Mental Illness, Inc., What Are The Facts About Mental Illness In The United States? (Washington, D.C.: National Committee Against Mental Illness, Inc., 1964), pp. 17-19.

It seems questionable that adequate psychiatric treatment and care can be provided on a per capita cost of $5.54 spent in 1964 in Montana. The per capita cost for adequate care in a public institution should be between $10.00 to $12.00 a day. The costs nationally in both Veterans Administration hospitals and private hospitals are in excess of $10.00 to $12.00 a day.[2]

One of the more frequently read comments in the newspapers during the 1965 legislative session was the lack of sufficient funds to finance needed services in the state. In the past, Montana has not been oriented to the necessity of adequate expenditures for the care and treatment of the mentally ill; yet nearly 40 percent of the total combined population of the eight state supported institutions are patients of the state mental hospital at Warm Springs.[3]

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[1]National Committee Against Mental Illness, Inc., What Are The Facts About Mental Illness In The United States? (Washington, D.C.: National Committee Against Mental Illness, Inc., 1964), pp. 17-19.

[2]Final Report of the Joint Commission on Mental Illness and Health, 1961, Action for Mental Health, Basic Books, Inc., New York, p. 18.

[3]State Department of Public Institutions, Report To The Honorable Tim Babcock, Governor Of The State Of Montana, For the Period Beginning July 1, 1962 and Terminating June 30, 1964.

After comparison with other states, it seems evident that Montana should seriously consider appropriating more money for the state's existing treatment and prevention facilities. As deduced from the experience of other states, better services in Montana could possibly reduce the outlay of monies through a reduction in patient tenure within the treatment facilities. What a society will decide to spend on mental health depends largely upon the value system in that society. Dr. Rashi Fein of the Joint Commission on Mental Illness and Health has this to say on expenditures for mental illness:[1]

> An economy can afford to spend whatever it desires to spend. All that is necessary in order to spend more on one thing is that we spend less on something else. We would have to give up something (in the short run) if expenditures on mental illness were increased (as pointed out previously, the long run situation might be far different). It is not for us to suggest the "proper" allocation of tax money, nor is it our place to suggest what the tax rate should be.
>
> What society can spend (and ultimately what society should spend) depends on the value system that society holds to. It is obvious that society can spend much more on mental illness . . . . . than it presently is doing. Whether or not it chooses to do so is another question.

## FINANCING TREATMENT

Health insurance can contribute substantially more financial support than it now does in Montana. Many group insurance programs do have limited provisions for psychiatric hospitalization; however, coverage is not sufficient. When first written, the federal group insurance program included 30 days of paid hospitalization per contract year for psychiatric

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[1] Rashi Fein, Ph.D., Economics of Mental Illness, Joint Commission on Mental Illness and Health, New York, Basic Books, Inc., 1958, p. 137.

treatment. This was lengthened to 120 days, and at present has been extended to cover the entire year. Under this program, outpatients are covered for electroshock therapy, but no provisions have been made for psychotherapy.

Insurance companies licensed to operate in Montana are beginning to offer more coverage with fewer restrictions for the care of mental illness. The trend is continuing and will prove to be an important element in furthering the community mental health concept. The American Medical Association has stated: "In the years to come, increased coverage of the cost of mental illness by private insurance companies should substantially augment private funds available for mental health needs."[1] The A.M.A. supports the principle that voluntary health insurance programs should be expanded, on a basis analogous to ordinary medical and surgical care, to include the cost of mental illness.

Even with a most enthusiastic response of insurance companies to offer this aforementioned coverage, the preponderance of the cost of financing our public treatment system will remain with the state of Montana for many years to come.[2]

Private funds will undoubtedly continue to bear a significant portion of the cost of psychiatric treatment. Admission statistics point up that about 50 percent of residents seen on a first-time basis

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[1] American Medical Association, Council on Mental Health Program, (Chicago: American Medical Association, 1962), p. 20.

[2] For a comprehensive coverage of the subject of insurance of mental illness, see Insurance Coverage of Mental Illness, 1962, Joint Information Service, Washington, D.C., November 1962.

seek help from a private source; a large percentage of these went to private psychiatrists. In light of this, and of the high cost of private treatment, it is presumed that substantial amounts are accruing to private funding.

## FINANCING A COMMUNITY MENTAL HEALTH CENTER

As conceptualized for Montana, a community mental health center would be one part of a tripartite complex. The other two units of the complex would house a mental retardation section and a juvenile rehabilitation section. In respect to this, all three units will be considered in the following cost analysis. It should be emphasized that the costs as reported are tentative - based on the best information now available, but certainly subject to change.

## MENTAL HEALTH SECTION

The mental health unit is anticipated to be more expensive to operate than the other two units, primarily due to the intensive nature of the treatment offered and the consequent necessity of a more elaborate team of professional personnel.

The construction of this section will be eligible for federal matching funds as appropriated by the National Congress. The total appropriation to Montana for mental health facility construction is in accordance with the following tentative schedule:

| PERIOD OF ALLOCATION | FEDERAL AMOUNT (55.23%) | STATE'S PORTION (44.77%) |
|---|---|---|
| Fiscal year 1965 | $133,880 | $108,522 |
| Fiscal year 1966 | 194,808 | 157,905 |
| Fiscal year 1967 | 253,527 | 205,498 |
| TOTALS | 582,215 | 471,925 |
| GRAND TOTAL | $1,054,140 | |

However, the fact must be considered that these federal funds, or any portion thereof, can be matched by non-profit organizations who are willing and able to provide the services required under Public Law 88-164.[1]

Operational costs were discussed during the 1965 legislative session because, up to that time at least, it appeared that these costs would have to be incurred wholly by the state. However, Congress is presently considering a bill which would provide funds to the states to help support the staffing of a comprehensive mental health center. This program would be a substantial assist to the state and would render the financial support of the suggested program more feasible. According to the latest information available to the project office (as of March 1965), the federal bill is House Bill 2985 which would provide funds for staffing on a decreasing level of support in accordance with the following schedule:

75 percent federal support for the first 15 months
60 percent federal support for the next 12 months
45 percent federal support for the next 12 months
30 percent federal support for the next 12 months

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1 See Appendix B.

MENTAL RETARDATION SECTION

Construction of this section will be eligible for federal funds in accordance with the following tentative schedule:

| PERIOD OF ALLOCATION | FEDERAL AMOUNT | STATE'S PORTION |
|---|---|---|
| Fiscal year 1965 | $100,000 | $ 81,075 |
| Fiscal year 1966 | 100,000 | 81,075 |
| Fiscal year 1967 | 100,000 | 81,075 |
| Fiscal year 1968 | 117,000 | 95,000 |
| TOTALS | 417,000 | 338,225 |
| GRAND TOTAL | $755,225 | |

It is not known to what extent, if any, that federal funds on a matching basis will be available to the state for staffing a mental retardation center.

JUVENILE REHABILITATION SECTION

No federal funds are available for construction of this section, hence it would have to be financed wholly from state funds. It is presumed that this would be equally true with respect to staffing this section.

SUMMARY OF CONSTRUCTION FUNDS FOR COMPREHENSIVE CENTER

Federal funds allocated to Montana may, at the discretion of the construction authority, be combined and utilized for either type of facility. The following schedule shows these funds considered as an entity and gives a summary analysis of total funds available for mental health and mental retardation construction.

| PERIOD OF ALLOCATION | FEDERAL AMOUNT | STATE'S PORTION |
|---|---|---|
| Fiscal year 1965 | $233,880 | $189,597 |
| Fiscal year 1966 | 294,808 | 238,980 |
| Fiscal year 1967 | 353,527 | 286,573 |
| Fiscal year 1968 | 117,000 | 95,000 |
| TOTALS | 999,215 | 810,150 |
| GRAND TOTAL | $1,809,365 | |

Annual operational costs for the three mentioned units are listed below. These tentative costs are based on presently available information and should not be construed as being static.

ESTIMATED ANNUAL OPERATIONAL COSTS
FOR COMPREHENSIVE CENTER

| SECTION | ANNUAL COST OF OPERATION |
|---|---|
| Mental Health | $347,688 |
| Mental Retardation | 144,780 |
| Juvenile Rehabilitation | 120,364 |
| Business Management | 235,680 |
| Additional Costs | 136,523 |
| TOTAL | 985,035 |

Patient fees will function in the support of a comprehensive center; however, fees will no doubt be small in proportion to the cost of operating the center. Annual collections from patient fees are expected to be a minimum of $35,754. In the final analysis, little doubt exists that public funds will be the mainstay of the mental health program for the anticipated future.

In the not too distant future, more information will be available on the cost of operating mental health facilities. The National Institute for Mental Health will be selecting various accounting firms, charging them with making cost analysis studies on the operation of mental health facilities. The resultant information will be made available to interested parties.

## FINANCIAL SUPPORT FOR TRAINING PROFESSIONALS

Continuing emphasis on staff development is a primary need of an energetic program. The program must necessarily receive sufficient financial support to enable it to function as it is intended. Both public and private agencies need to be cognizant of their continuing responsibility to provide such fringe benefits as training stipends and travel and per diem allowances to further educational opportunities of their staffs. This training may be given through such media as graduate work, workshops, seminars, or simply, meetings. Effort should be made to expand budgetary allowances so that such an endeavor could be carried on at a level at least commensurate with those sponsored in comparable states. Further consideration should be given to the need to provide educational allowances to students interested in careers in mental health.

## LEGISLATION

House Bill 535 of the 1965 Legislature provided for 1.3 million dollars to be utilized in the construction of a diagnostic center. This amount is intended to match the approximately $999,000 federal monies that will be available (see last schedule in this chapter) to the state on a matching basis over the next four years. Funds allocated by Montana

not used for matching will be used in the construction of a juvenile rehabilitation section within the tri-complex. This legislation has particular significance when considered in the light of many remarks of the legislators themselves who felt that even two years ago such legislation would have utterly failed to receive any but very passive recognition.

CHAPTER XI

# GOALS AND PRIORITIES

## SERVICES

### Goals

The provision of mental health services has been evaluated in previous chapters; data has been presented regarding available services and their location. This data indicates that most of the service extended by any of the treatment sources is given to the people who live within the county where services are located. This is particularly true in the instance of mental hygiene clinics where nearly three-fourths of the service is given to residents in the site county.

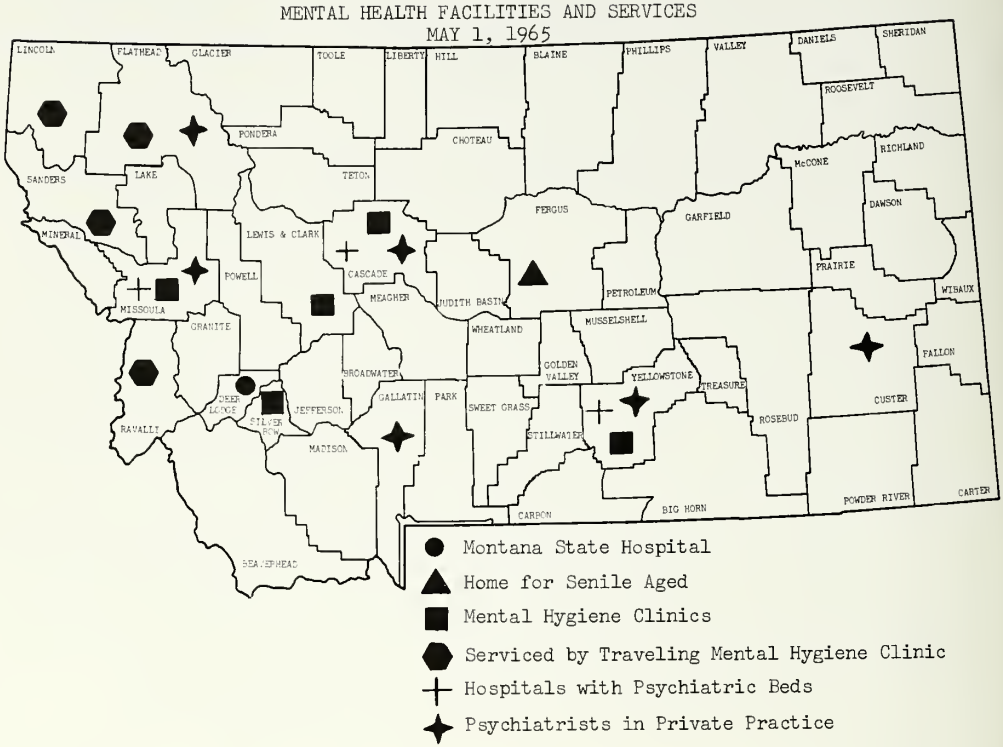
A particular concern repeatedly emphasized by local committees of the planning effort is the need for provision of locally based mental health services to the counties now receiving little or no such service.

The statistics gathered by the Project conclusively point up an undeniable need for mental health services in eastern and northern Montana. The lack of such facility in these areas is in itself significant indication that service should be extended to this part of the state's populace. (See Map 11.1)

Indeed there seems reason to purport that no area of the state is receiving adequate mental health services in terms of quantity. Even in the populace counties where a more adequate cross section of services is provided, there are segments of the populace that are not being serviced.

MAP 11.1

MONTANA
MENTAL HEALTH FACILITIES AND SERVICES
MAY 1, 1965




Priorities

Of necessity, the assignment of priority must involve an over-look of services to be considered. A basic concept of the planning in Montana has been that no new mental hospitals, of the type now existing at Warm Springs, should be constructed; therefore, this treatment alternative has been excluded. There is an apparent need for decentralization of services making them more easily accessible to a larger portion of the state's people. Such decentralization can of course be effected by either a public or private resource. Ideally, private enterprise can and should

provide needed services. However, where necessary services cannot be thus provided, the obligation falls to other agencies - such as government - to augment areas in which services are lacking.

Since private psychiatry and its related mental health components have either been unwilling or unable to provide services in some areas, government should endeavor to do so.

The most financially feasible and seemingly the most sought-after service in Montana is additional outpatient clinic services. It is therefore the recommendation of the Planning Committee that outpatient clinics be considered as the first priority of needed services.

Because of the lack of services previously noted, it is further recommended that the first site to be considered for establishing such a clinic should be in that portion of Montana where no such services are presently being provided.

## CONSTRUCTION

### Goals

Perhaps one of the most difficult obstacles to be met in initiating construction for public benefit is that of budgetary commitment. Current demand on existing resources in Montana is sufficiently great to suggest that to base the expansion of service on monetary availability alone would almost preclude the introduction of any new commitment. Obviously then, any new demand on the resources of the state must be of such a nature that the provision of supporting funds becomes, in a sense, secondary to the essentiality of providing the service.

To create such an attitude towards construction of adequate mental health facilities has been one of the goals of the Planning Committee.

Projected for the state are three comprehensive mental health centers to be constructed at the sites previously noted in Chapter Nine.

Although no construction for additional services is recommended at Montana State Hospital, it is recognized that adequate facility does not exist for many services that are presently part of the Hospital's program. Modernization of the State Hospital physical plant to enable it to conform more closely to the recommended treatment practices and thus allow for an acceptable therapeutic environment is a goal of Montana's overall program.

There are a number of supportive programs which could be advantageously employed by the state to assist in prevention, treatment and aftercare. Important among these would be the provision of intermediary facilities for mental patients. As suggested by a masters degree thesis submitted at Montana State College in Bozeman, if intermediary facilities were available in Montana, 55 percent of the patients in Montana State Hospital could be released to a partial psychiatric care setting.[1]

Certainly there are other goals that undoubtedly are important and could justifiably be assigned a primary emphasis; however, it is felt that the foregoing represent those at present most significant to Montana's requirements.

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[1]Madeline Samson, "The Need For Partial Psychiatric Care Facilities In Montana", (Unpublished Masters Thesis School of Nursing, Montana State College, 1964), p. 28.

Priorities

In the opinion of the Planning Committee, the construction of comprehensive centers in the three proposed areas, should receive first priority in Montana's plan for new mental health facility construction. Inherent within the treatment schedule of a comprehensive center would be the function of providing residential treatment for disturbed children. (A discussion of the areas has been given in Chapter Nine.[1])

There is little doubt that the State Hospital will continue to function in its most vital role of providing service to the mental patient who must be institutionalized. Therefore it is felt that modernization of Montana State Hospital's physical plant should be high on the priority list, and that in construction planning it should be second only to the building of comprehensive centers. If financially possible, it is recommended that funds be provided simultaneously to the State Hospital for modernization and to comprehensive centers for new construction.

## STAFFING

Goals

Montana suffers from much the same malady as many other states in consideration of mental health programing, i.e., insufficient staff to meet program demands.

In Montana, it has been difficult to attract new personnel into the mental health system. Currently there are several vacancies that have not been filled. Shortages of personnel exist in both professional and in line staffing.

[1] Supra, p. 203.

Montana State Hospital has particularly high personnel turnover rates. A prominent factor negating against retention of personnel is the relative isolation of the Hospital site. This factor also makes difficult the employment of personnel.

Perhaps nothing is more important to a mental health program than knowledgable and qualified personnel. Yet, the State of Montana Joint Merit System report for the 1963-1964 fiscal year shows that the Department of Mental Hygiene (Montana's outpatient clinic system) has the greatest percentage loss of personnel of any department in the state. This could likely be the case again in the 1964-1965 fiscal year.

If staff is to be acquired and retained, it seems essential that there be a program that will provide professional and economic incentive. This would necessitate, among other things, close communication between community and state level directors; salaries which are both competitive and commensurate with skill, experience and training; a high degree of coordination between clinic and institution functions; and ongoing training through workshops, seminars or conferences to keep abreast of current thinking and practice. Not only should personnel have the opportunity of attending training sessions or workshops, but such ongoing training should be mandatory to keep up to date with rapidly changing methods and techniques.

Recruitment poses many additional problems. Montana has not developed an effectual system for the recruitment of sufficient staff. A program that could partially, at least, remedy this situation would be the utilization of advanced college students through summer employment and/or the development of a placement program for graduate students

through the school year. Those now being trained offer a great potential source of supply; and if they were to be exposed to an aggressive training program in Montana during their academic years, the chances of employing and retaining them in the state would be greatly enhanced. Experience of other agencies in the state reflects that a placement program for advanced college students must be adequately supported with a sound educational leave allowance program. This program will necessarily have to include monthly stipend payments as well as fees for graduate students at appropriate professional schools. Tied in with such a program should be a contract arrangement between perhaps the Department of Institutions and the prospective student that the student would return to work in the state for a specified period of time, following a successful completion of his graduate work.

Additional staff for supportive agencies is recognized as being of great importance to the overall effectiveness of a mental health program in Montana. There is a need for school psychologists, school social workers, public health nurses, counselors and others to assist in prevention detection, and treatment of the mentally ill.

A great deterrent to the attraction and employment of the mental health professional in Montana is the lack of appropriate professional settings. The construction of comprehensive mental health centers, in addition to providing much needed services, would also provide a physical environment attractive to the professional. Since the centers will be constructed in the larger metropolitan centers of Montana, professional personnel would have access to the services and recreational opportunities that cities can offer.

Priorities

In anticipation of new staffing required for the proposed comprehensive centers, and with the known need that already exists in our presently understaffed facilities, it seems apparent that Montana should consider inovations in a program that would be more conducive to the acquisition and retention of the mental health professional.

It seems evident that a merit program for the Department of Institutions could be a significant factor in developing a planned program of recruitment and training of mental health professionals. Such a program properly initiated in all of the state's institutions is highly recommended by the Planning Committee. A feasible method of effectuating such a program would be under the existing merit system.

Priorities for staffing mental health facilities should be in the following order:

First - Comprehensive Centers (when constructed)

Second - Outpatient Clinics

Third - Montana State Hospital

Fourth - Supportive Facilities

SUMMARY

Provision of services, construction of new facility and acquisition of staff most certainly must be accomplished in accordance with the ability of the state of Montana to support these requirements.

It is evident that the most feasible programs should be given emphasis. The passage of House Bill 535, providing monies for construction of a comprehensive center, establishes this goal for Montana; every effort

should be expended to implement its construction as soon as possible. In the opinion of the Planning Committee, such a center for diagnosis and treatment holds the first construction priority for Montana; on the basis of careful evaluative criteria, the center should be constructed at either Billings or Great Falls.

If Montana is to bolster its program of prevention and detection of mental illness, the outpatient clinic system must be allocated additional funds to enable more attractive salaries and benefits for attracting and retaining mental health professionals. In addition, new clinics need to be established with the eastern portion of Montana as first priority. Second priority for mental health clinic facilities should be northern Montana, followed by northwestern Montana and southwestern Montana, in that order.

The continuation of a planning effort would greatly facilitate the proper implementaion of the goals for Montana. Priorities are subject to change; there should be a body charged with continual evaluation of Montana's needs and the revision and updating of existent planning.

CHAPTER XII

## SUMMARY AND RECOMMENDATIONS

The late President John F. Kennedy was instrumental in bringing to the attention of the nation the need for improved services to our mentally ill and mentally retarded. In a 1963 address to Congress, he stated:[1]

> We as a nation have long neglected the mentally ill and mentally retarded. This neglect must end if our nation is to live up to its standards of compassion and dignity and achieve the maximum use of its manpower.

As a result of this urgent appeal from the President, on July 1, 1963, Congress allocated a grant of monies to each of the 50 states to conduct comprehensive mental health planning programs for each state. These programs were to be completed within a period of two years, or by June 30, 1965.

To conduct the necessary research for this planning program, a committee composed of 50 individuals representing varied disciplines through the state was formed by the mental health authority. A smaller 12-man steering committee was selected from the larger group to provide a functional nucleus. Approximately 500 other Montanans were organized into county committees to help obtain some of the data for this research and planning program. The committee members are representative of most of the public and private professional organizations in Montana that have a continuing interest in the mental health needs of Montana citizens.

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[1] U.S., Congressional Record, 88th Cong., 1st Sess., 1963, House of Representatives, Doc. No. 58, p. 13.

This plan has focused on modern concepts of care and treatment of the mentally ill. This program would include a complete range of mental health services for all degrees of mental illness from minor to major disorders. Facilities for short, medium and long-range care programs for all ages are indicated. Of great importance is a program that would provide treatment of the patient in or near his home community instead of isolation in a strange environment removed from the influence of home and family.

The Planning Committee believes a step in the direction of community based programming would be the establishment in our major cities of what are termed "comprehensive community health centers".

The "comprehensive community center" in Montana has fortunately been defined as a concept and not specifically as a building. The center as a concept involves all community agencies, e.g., the home, court, the public health nurse, the welfare department, etc., working in harmony with each other in promoting better mental health and treatment in their community. A structure to house the operation is an evident necessity; however, it is equally as important to visualize the center as an integrated community effort.

The state has been divided into three comprehensive mental health districts, with district headquarters to be located at Missoula, Great Falls, and Billings. This center would furnish each district with five functions of care.

1. Inpatient
2. Outpatient
3. Partial hospitalization
4. Twenty-four hour emergency care (in at least one of the first three services)
5. Consultation and educational service to community agencies.

The geographical distance and population dispersion required that each comprehensive mental health district be delineated into three mental hygiene districts with each district outside the headquarter city having a mental hygiene clinic. This clinic would be an integral part of the total comprehensive approach.

The adage - "out of sight--out of mind" - is frequently employed but never seems to work in resolving the problems of mankind. Our problems continue to grow and a need for a dynamic program is close at hand. To simply hope to arrest mental illness is a losing proposition -- both morally and financially. Prevention of mental disorders, care and treatment offered in the community setting which assists the individual to recover his dignity and ability to maintain himself -- these are the positive approaches which are so vitally necessary.

The Committee discussed at length the difficult ramifications of Montana's bold new approach for the treatment and care of the state's mentally ill. Concern on an array of matters was expressed, and individual philosophy was recognized and discussed. The program slowly but steadily developed with the following recommendations being made.

The State Planning Committee recommends that:

1. As President Kennedy pointed out in his address to Congress in February 1963, "Central to a new mental health program is comprehensive community care". For this reason we should aim at developing comprehensive community mental health centers, outpatient mental hygiene clinics and psychiatric services in general hospitals. These facilities should be coordinated with all other community agencies relating to mental health,

such as schools, clergy, physicians, welfare, rehabilitation, public health nursing, law enforcement, etc. p. 2, 3.

2. It is recommended that provision be made to plan for more adequate prevention services and to provide for early treatment including the participation of local public and private agencies. p. 5.

3. Montana's mental hygiene clinic program should be expanded, staffing should be increased as necessary, and services should be strengthened and continued in areas of child guidance. pp. 39, 40, 41, 255.

4. In consideration of the large numbers of children admitted into psychiatric care each year, it is recommended that the Department of Public Institutions establish a residential treatment center for disturbed children. This facility must be physically removed from the State Hospital. pp. 48, 54, 55, 57.

5. Mental hygiene clinics in each mental hygiene district should consider travel within their districts to give consultative services to community agencies. pp. 70, 72.

6. Through intelligent use of teachers, school counselors, psychologists, school nurses and school social workers, school districts can effectively help children in overcoming emotional problems. Therefore, it is strongly recommended that until such time as school districts can provide these services as part of the school program, the districts establish patterns of pupil referral to existing resource persons or agencies within the community. pp. 121, 253.

7. Greater emphasis should be given in teacher training programs to help better prepare prospective teachers for recognizing and referring,

as early as possible, any significant deviation from normal pupil growth, behavior and learning patterns. pp. 128, 170, 171.

8. Intensive effort should be made to find the supporting resources which would allow patients who are no longer requiring the specialized service of a comprehensive mental health center or state hospital to return to community life. pp. 179, 180. (See Chapter VI)

9. Montana should pursue the establishment of forest and conservation camps for juveniles and young men and others on a pattern similar to successful operations throughout the West, and make maximum use of all other programs which now exist or become available. p. 148.

10. Montana should develop graduate and undergraduate programs in the fields of social work, clinical psychology and psychiatric nursing. pp. 157, 159, 160, 162, 163, 167, 252, 253.

11. Immediate steps should be taken by the Montana university system to enable Montana students to enroll in graduate schools under the Western Interstate Commission for Higher Education and other programs. p. 161.

12. Encouragement to provide more trained psychiatric nurses through such means as more emphasis on psychiatric nursing in the basic program, in-service education programs, and W.I.C.H.E. pp. 169, 170.

13. It is recommended that there be established under the direction of the mental health authority a comprehensive program of public education and information concerning mental illness. pp. 173, 174.

14. Every effort should be made to reduce the resident population load of Montana State Hospital to a figure not in excess of 1,000 beds. Present facility should be upgraded but there should <u>not</u> be any new

construction intended to increase the resident population. No more large mental hospitals should be built in Montana. pp. 177, 178, 248.

15. No community psychiatric inpatient service should exceed 300 beds. p. 178.

16. The concept of comprehensive community mental health centers can be utilized in areas even though they may not have a construction project. pp. 179, 180.

17. Consultation and education will be available to community agencies and professional personnel. Federal programs such as T.A.P. and others may be utilized. pp. 182, 183.

18. Facilities should be used for the purposes for which programmed and staffed, and operated at highest efficiency. pp. 187, 198, 200.

19. Volunteers should be an integral part of the comprehensive mental health center as well as in other mental health programs. p. 187.

20. Existing Montana laws should be changed concerning the mentally ill, and wherever possible the admission of patients to mental health facilities should follow the same procedure as admission to a general hospital. p. 188.

21. Psychiatric units in the comprehensive mental health center should be responsible for a minimum of 20 and a maximum of 25 beds. pp. 181, 191.

22. Although the psychiatrist must carry the authority and final responsibility for the professional activities of the clinical team, he will encourage the participation of all mental health professionals in the therapy process to the extent that their training qualifies them to render service. pp. 189, 191.

23. Easy movement of patients between agencies and community facilities should be possible. pp. 192, 193.

24. Mental health planning should be a continued process in the future with a defined and operational staff. pp. 193, 194, 195, 255.

25. All present or new mental health services in Montana should have built-in evaluation programs. pp. 194, 195.

26. Councils should be set up on state and district levels to coordinate and facilitate mental health programming. pp. 194, 196, 197.

27. There should be cooperation and agreement between state and federal agencies in developing a total care program for the care of the mentally ill. pp. 196, 197.

28. In psychiatric facilities, administration should be the responsibility of a psychiatrically trained medical administrator. pp. 190, 199.

29. Construction design should be flexible to meet expansion or modification needs and to meet changing psychiatric philosophy. pp. 200, 201, 202.

30. A comprehensive center should be a part or close affiliate of a general hospital. pp. 202, 254, 255.

31. All mental hygiene districts should have monies made available for the establishment of mental health clinics. pp. 221, 222, 223, 232, 233, 255.

32. Facilities for treatment should be located in terms of easy accessibility to the area of potential need. pp. 222, 247.

33. Training stipends should be provided to mental health personnel, undergraduates, and graduates for continuing professional enrichment. p. 245.

34. Mental health services should be extended as rapidly as possible to eastern and northern Montana. pp. 247, 249.

35. In instances where private enterprise cannot or will not provide needed mental health services, other agencies such as state and local government should endeavor to augment those areas which are lacking. p. 249.

36. Intermediary facilities should be provided to house mental patients in partial psychiatric care settings. p. 250.

37. It is recommended that Montana State Hospital's physical plant be modernized to provide an acceptable therapeutic setting. p. 251.

38. To help attract and retain mental health personnel, programs of professional and economic incentive should be provided that would establish effective communication, competitive salaries, coordination between mental health treatment facilities, and ongoing training opportunities. p. 252.

## EVALUATION OF MENTAL HEALTH PLANNING

The project time was divided into nine phases with a target date established for completion by the Planning Committee.[1] The planning process kept pace with the target dates.

In all planning effort, difficulties arise that have effect on the planning program. One significant difficulty in Montana is the largeness of the state and the consequent distances which must be traveled. Project staff was required to travel thousands of in-state miles during the process of organization of working committees, and in the compilation and elucidation of the statistical data utilized. This travel proved very time consuming and with only limited time available to complete the project, the staff, of necessity, worked long past regular hours to compensate for time taken up in travel and committee work.

Availability of statistical information presented many challenging and interesting problems. Montana has not been geared to research and much of the information presented in the plan had to be ferreted out through original procedures. However, some of the difficulties which might be anticipated in such an undertaking did not materialize because of the excellent cooperation and support the project received from many quarters. Existing state government agencies were extremely supportive and cooperated extensively with the project. Many more community problems would have been restrictive to project goals if it had not been for the fine support received from professional and social organizations within the communities.

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[1] See Appendix E.

Public indifference to mental health was experienced and a general lack of understanding of mental health problems on the part of the public was noted.

The planning effort was instrumental in promoting some substantial support for mental health throughout the state. The committees that were organized to help gather data for the project have been functional in the establishment of better community relations. The Planning Committee, which had representation from several state agencies as well as other interests, was the first such planning effort and was successful in the establishment of inter-agency cooperation in planning for mental health. The interest and willingness displayed by the Planning Committee members in seeking solutions to Montana's mental health problems was indicative that such a group could function on a continuing basis in working for the betterment of mental health in Montana. As a result of the planning effort, a great deal of public support was mustered in all parts of the state which was a prominent factor in getting favorable legislation through the last (1965) legislative session.

Some significant legislation that was sponsored and enacted as a direct result of this planning effort was the provision of monies in House Bill 535 for the establishment of a comprehensive center for the state. Although it is certain that final passage came about from the efforts of many, the planning effort provided the impetus and coordination which was required. Other bills were supported by the planning group, and it is significant that the majority received sufficient support for passage. The Planning Committee sought revision in the laws having to do with commitment procedure, but when it was seen that

agreement could not be reached on some of the more salient issues thus in effect negating the desired change, the Planning Committee wisely supported the elimination of the total revision from legislative consideration.

Goals have been established for the provision and extension of mental health services to lacking areas in the state. Important among these were the goals of three comprehensive centers and the eventual establishment of a total of nine mental hygiene clinics.

Some side effects that the project has contributed to the betterment of the overall mental health program in Montana have been a better reporting system for the mental hygiene clinics and the installation of a modern I.B.M. plant at the State Hospital. The project required some information regarding clinic operation and initiated a form that would provide the necessary data. The clinic system subsequently adopted the form as its permanent reporting method. The project received permission to purchase an I.B.M. accounting machine, 402 series, for purposes of making a detailed analysis of the punched card system available at the State Hospital. This machine proved invaluable to the planning effort, and upon termination of the project the machine will revert to the State Hospital for their use. Coupled with the I.B.M. system they presently have available to them, this will enable the State Hospital to participate in more advanced reporting techniques.

If further federal assistance becomes available to Montana in support of mental health, it is suggested that a vital program that needs bolstering in the state is in the area of staffing. Federal aid could

be extremely valuable in helping Montana to fill gaps in its staffing complement that need immediate attention, but due to existent demand on available state funds could not be taken care of through normal state expansion of services.

# A P P E N D I C E S

# APPENDIX A

## GENERAL DATA OF SURVEY POPULATION

MAP I

13 ADMINISTRATIVE DISTRICTS
SHOWING ASSIGNED NUMBERS

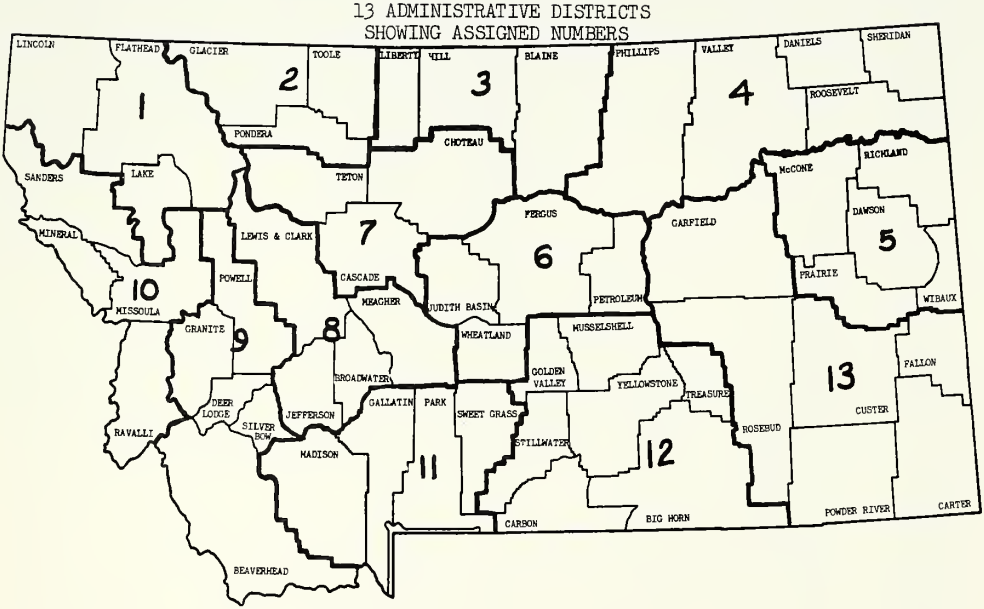

TABLE 1

FIRST ADMISSION AGE-SEX ADJUSTED RATES
PER 1,000 MONTANA POPULATION BY COUNTY
FOUR YEAR AVERAGE 1960-1963

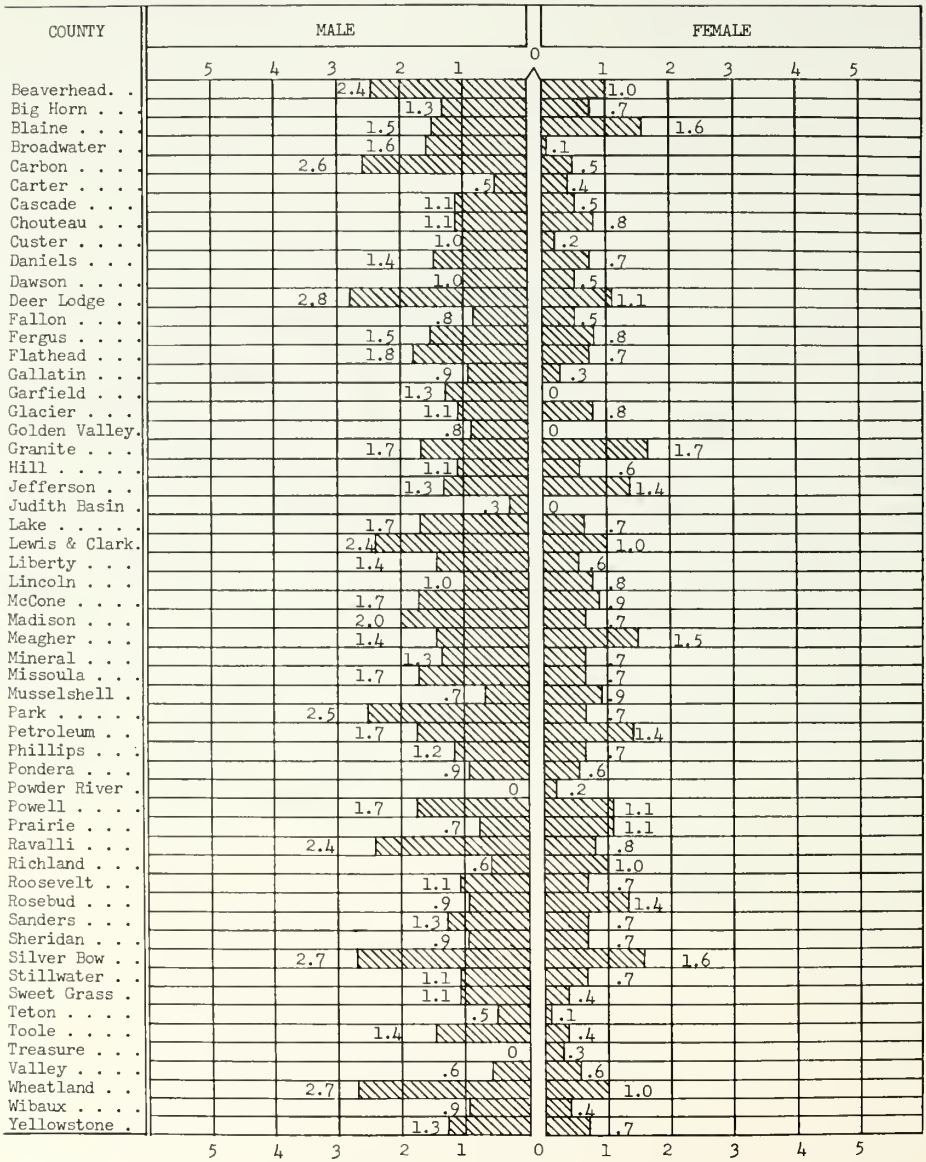
COUNTY
MALE
FEMALE
5 4 3 2 1 0 1 2 3 4 5
Beaverhead. . 2.4 1.0
Big Horn . . . 1.3 .7
Blaine . . . . 1.5 1.6
Broadwater . . 1.6 1.1
Carbon . . . . 2.6 .5
Carter . . . . .5 .4
Cascade . . . 1.1 .5
Chouteau . . . 1.1 .8
Custer . . . . 1.0 1.2
Daniels . . . 1.4 .7
Dawson . . . . 1.0 .5
Deer Lodge . . 2.8 1.1
Fallon . . . . .8 .5
Fergus . . . . 1.5 .8
Flathead . . . 1.8 .7
Gallatin . . . .9 .3
Garfield . . . 1.3 0
Glacier . . . 1.1 .8
Golden Valley. .8 0
Granite . . . 1.7 1.7
Hill . . . . . 1.1 .6
Jefferson . . 1.3 1.4
Judith Basin . .3 0
Lake . . . . . 1.7 .7
Lewis & Clark. 2.4 1.0
Liberty . . . 1.4 .6
Lincoln . . . 1.0 .8
McCone . . . . 1.7 .9
Madison . . . 2.0 .7
Meagher . . . 1.4 1.5
Mineral . . . 1.3 .7
Missoula . . . 1.7 .7
Musselshell . .7 .9
Park . . . . . 2.5 .7
Petroleum . . 1.7 1.4
Phillips . . . 1.2 .7
Pondera . . . .9 .6
Powder River . 0 .2
Powell . . . . 1.7 1.1
Prairie . . . .7 1.1
Ravalli . . . 2.4 .8
Richland . . . .6 1.0
Roosevelt . . 1.1 .7
Rosebud . . . .9 1.4
Sanders . . . 1.3 .7
Sheridan . . . .9 .7
Silver Bow . . 2.7 1.6
Stillwater . . 1.1 .7
Sweet Grass . 1.1 .4
Teton . . . . .5 .1
Toole . . . . 1.4 .4
Treasure . . . 0 .3
Valley . . . . .6 .6
Wheatland . . 2.7 1.0
Wibaux . . . . .9 .4
Yellowstone . 1.3 .7
5 4 3 2 1 0 1 2 3 4 5

TABLE 2

T SCORES REPORTED BY 56 MONTANA COUNTIES FOR 41 VARIABLES
(pp. 276-279)

The scores in this table are not percentages but standardized scores permitting the comparison of the relative position of one county to another. The mean point of a standardized score is 50.[1]

[1] Supra, p. 216.

| | 1. Percent of total population - urban | 2. Percent urban population increased 1950-1960 | 3. Percent of total population - rural farm | 4. Percent of families with incomes under $3,000 | 5. Population | 6. Uniform crime rates - burglary | 7. Uniform crime rates - auto theft | 8. Uniform crime rates - total crimes | 9. Median family income | 10. Population density - persons per square mile | 11. Percent of civilian labor force which is female | 12. Percent of employed civilians holding white collar jobs |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Beaverhead | 59.52 | 52.07 | 47.88 | 49.00 | 46.90 | 52.78 | 48.12 | 53.47 | 50.90 | 45.60 | 54.06 | 52.46 |
| Big Horn | 51.53 | 44.78 | 52.49 | 57.97 | 48.70 | 47.84 | 41.16 | 43.45 | 41.81 | 46.29 | 46.91 | 46.73 |
| Blaine | 42.01 | 44.78 | 52.61 | 57.72 | 47.47 | 39.12 | 44.30 | 37.63 | 42.41 | 46.20 | 44.30 | 42.59 |
| Broadwater | 42.01 | 44.78 | 50.24 | 60.15 | 44.09 | 57.75 | 51.74 | 61.69 | 36.17 | 46.59 | 44.53 | 47.10 |
| Carbon | 42.01 | 44.78 | 53.85 | 57.08 | 47.62 | 45.35 | 46.11 | 44.48 | 41.24 | 48.27 | 50.72 | 46.85 |
| Carter | 42.01 | 44.78 | 67.58 | 56.95 | 43.90 | 50.00 | 50.00 | 50.00 | 39.25 | 45.11 | 45.96 | 38.07 |
| Cascade | 68.80 | 71.33 | 36.10 | 36.44 | 89.21 | 66.92 | 78.49 | 74.23 | 65.98 | 71.64 | 67.97 | 68.44 |
| Chouteau | 42.01 | 44.78 | 61.72 | 41.05 | 47.00 | 44.53 | 57.72 | 54.08 | 59.83 | 46.20 | 36.91 | 42.34 |
| Custer | 66.96 | 47.38 | 41.13 | 46.31 | 50.75 | 55.92 | 66.29 | 62.60 | 53.26 | 47.78 | 61.20 | 66.12 |
| Daniels | 42.01 | 44.78 | 52.49 | 55.54 | 44.70 | 40.82 | 46.73 | 43.27 | 43.46 | 46.89 | 39.06 | 43.32 |
| Dawson | 61.56 | 64.16 | 43.32 | 42.21 | 50.17 | 55.31 | 46.19 | 51.66 | 59.01 | 49.46 | 49.77 | 61.37 |
| Deer Lodge | 64.09 | 48.79 | 34.21 | 35.03 | 54.21 | 41.99 | 58.76 | 45.63 | 51.25 | 69.36 | 56.20 | 45.15 |
| Fallon | 42.01 | 44.78 | 51.13 | 51.69 | 44.86 | 61.57 | 42.36 | 51.51 | 46.47 | 46.69 | 44.06 | 49.78 |
| Fergus | 60.03 | 51.96 | 49.30 | 49.26 | 51.26 | 56.25 | 48.89 | 53.45 | 50.81 | 47.58 | 58.10 | 53.56 |
| Flathead | 55.59 | 45.29 | 39.89 | 43.87 | 63.36 | 54.54 | 49.56 | 52.12 | 56.65 | 50.65 | 58.82 | 62.10 |
| Gallatin | 59.52 | 54.95 | 42.02 | 45.54 | 58.94 | 64.53 | 44.96 | 56.19 | 56.18 | 54.51 | 63.58 | 66.49 |
| Garfield | 42.01 | 44.78 | 69.71 | 77.46 | 43.57 | 40.53 | 44.39 | 41.52 | 26.29 | 44.71 | 46.91 | 33.68 |
| Glacier | 55.39 | 57.21 | 40.66 | 55.03 | 49.69 | 44.32 | 47.26 | 45.86 | 53.39 | 48.18 | 53.48 | 56.73 |
| Golden Valley | 42.01 | 44.78 | 64.03 | 63.62 | 43.07 | 35.22 | 40.36 | 42.26 | 36.98 | 45.30 | 22.39 | 32.83 |
| Granite | 42.01 | 44.78 | 47.28 | 44.38 | 44.23 | 43.95 | 40.36 | 48.91 | 50.01 | 46.00 | 47.39 | 42.71 |
| Hill | 61.67 | 63.31 | 42.61 | 37.08 | 54.22 | 53.28 | 54.90 | 50.48 | 68.58 | 50.65 | 58.58 | 56.49 |
| Jefferson | 42.01 | 44.78 | 46.28 | 50.28 | 45.05 | 59.72 | 44.07 | 64.90 | 50.77 | 46.89 | 60.01 | 49.54 |
| Judith Basin | 42.01 | 44.78 | 62.20 | 46.18 | 44.27 | 43.75 | 42.95 | 41.24 | 55.77 | 45.90 | 42.87 | 47.59 |
| Lake | 42.01 | 44.78 | 53.26 | 60.41 | 50.67 | 40.84 | 45.84 | 39.28 | 39.01 | 52.93 | 56.44 | 50.51 |
| Lewis & Clark | 66.65 | 53.31 | 36.52 | 34.00 | 60.20 | 42.17 | 46.34 | 45.39 | 72.24 | 52.33 | 80.49 | 78.80 |
| Liberty | 42.01 | 44.78 | 47.34 | 38.74 | 43.96 | 49.27 | 70.75 | 52.10 | 63.44 | 46.10 | 41.44 | 46.73 |
| Lincoln | 49.72 | 44.78 | 37.23 | 39.77 | 50.31 | 58.32 | 49.90 | 56.15 | 57.97 | 47.68 | 41.44 | 52.83 |
| McCone | 42.01 | 44.78 | 69.89 | 65.79 | 44.42 | 39.97 | 49.96 | 40.72 | 35.10 | 45.60 | 40.96 | 38.68 |
| Madison | 42.01 | 44.78 | 55.04 | 58.62 | 45.63 | 45.32 | 44.96 | 47.41 | 43.20 | 45.80 | 47.39 | 35.88 |
| Meagher | 42.01 | 44.78 | 48.29 | 46.05 | 43.97 | 73.46 | 64.75 | 77.14 | 50.18 | 45.40 | 51.20 | 35.76 |
| Mineral | 42.01 | 44.78 | 37.05 | 34.51 | 44.24 | 50.82 | 42.99 | 42.97 | 61.98 | 46.79 | 45.01 | 54.29 |
| Missoula | 65.63 | 65.91 | 35.39 | 39.26 | 70.84 | 51.84 | 62.85 | 58.15 | 62.14 | 61.24 | 64.53 | 69.41 |
| Musselshell | 61.84 | 44.50 | 42.79 | 53.87 | 45.43 | 42.76 | 51.78 | 44.19 | 49.86 | 46.89 | 58.82 | 54.29 |
| Park | 63.34 | 48.79 | 41.13 | 44.38 | 50.72 | 73.60 | 54.90 | 63.11 | 54.62 | 49.26 | 53.58 | 51.98 |
| Petroleum | 42.01 | 44.78 | 65.75 | 41.05 | 42.87 | 64.67 | 58.20 | 56.39 | 57.03 | 44.81 | 28.82 | 33.07 |
| Phillips | 42.01 | 44.78 | 55.45 | 57.46 | 46.15 | 39.59 | 50.94 | 40.99 | 41.49 | 45.50 | 50.49 | 46.73 |
| Pondera | 53.89 | 44.78 | 53.97 | 46.18 | 47.19 | 42.78 | 43.49 | 39.82 | 52.07 | 48.97 | 43.58 | 48.80 |
| Powder River | 42.01 | 44.78 | 70.60 | 54.26 | 43.89 | 37.33 | 40.36 | 39.97 | 47.97 | 45.11 | 37.39 | 37.22 |
| Powell | 64.84 | 58.28 | 40.48 | 41.82 | 46.78 | 41.23 | 43.78 | 41.44 | 56.53 | 47.28 | 47.15 | 47.71 |
| Prairie | 42.01 | 44.78 | 55.39 | 55.15 | 43.78 | 48.84 | 43.80 | 42.58 | 43.20 | 45.60 | 41.91 | 39.54 |
| Ravalli | 42.01 | 44.78 | 51.60 | 67.97 | 50.19 | 45.03 | 48.76 | 43.07 | 33.70 | 49.46 | 51.20 | 51.24 |
| Richland | 56.85 | 52.97 | 50.24 | 54.90 | 49.01 | 45.24 | 47.20 | 50.18 | 43.08 | 49.36 | 50.72 | 57.34 |
| Roosevelt | 52.45 | 67.49 | 45.69 | 57.59 | 49.80 | 42.85 | 40.36 | 40.97 | 44.54 | 49.17 | 52.39 | 56.37 |
| Rosebud | 42.01 | 44.78 | 48.23 | 58.74 | 46.26 | 42.88 | 42.94 | 39.59 | 42.16 | 45.50 | 57.15 | 50.39 |
| Sanders | 42.01 | 44.78 | 46.57 | 44.90 | 46.70 | 51.29 | 41.52 | 45.59 | 50.48 | 46.79 | 47.63 | 49.29 |
| Sheridan | 42.01 | 44.78 | 58.88 | 54.00 | 46.43 | 35.22 | 42.83 | 37.02 | 44.36 | 48.08 | 38.34 | 46.37 |
| Silver Bow | 71.50 | 47.38 | 33.68 | 42.33 | 71.98 | 65.93 | 75.20 | 70.52 | 55.06 | 108.57 | 60.49 | 60.63 |
| Stillwater | 42.01 | 44.78 | 54.98 | 46.69 | 45.83 | 44.75 | 40.36 | 40.27 | 47.87 | 47.38 | 49.77 | 43.32 |
| Sweet Grass | 42.01 | 44.78 | 58.11 | 54.90 | 44.40 | 51.22 | 47.63 | 50.06 | 41.20 | 46.10 | 59.06 | 44.78 |
| Teton | 42.01 | 44.78 | 60.18 | 50.41 | 46.96 | 36.66 | 44.73 | 42.17 | 54.82 | 47.48 | 42.87 | 47.59 |
| Toole | 59.35 | 62.52 | 45.33 | 34.51 | 47.35 | 50.54 | 56.50 | 52.03 | 65.85 | 48.37 | 48.10 | 56.24 |
| Treasure | 42.01 | 44.78 | 66.93 | 60.28 | 43.16 | 35.22 | 40.36 | 35.77 | 44.19 | 45.70 | 37.15 | 37.83 |
| Valley | 54.81 | 82.86 | 44.21 | 45.28 | 53.21 | 61.72 | 56.23 | 60.83 | 55.67 | 47.68 | 53.34 | 56.12 |
| Wheatland | 42.01 | 44.78 | 41.49 | 46.18 | 44.24 | 61.32 | 42.99 | 54.67 | 56.76 | 46.39 | 54.53 | 47.59 |
| Wibaux | 42.01 | 44.78 | 62.73 | 74.64 | 43.39 | 63.13 | 45.06 | 35.77 | 28.04 | 46.20 | 45.72 | 48.93 |
| Yellowstone | 70.23 | 92.24 | 36.87 | 35.54 | 92.78 | 68.19 | 86.06 | 77.65 | 67.70 | 74.02 | 67.15 | 71.73 |

| | 13. Per capita state and county expenditures for Aid to Dependent Children | 14. Percent non-white | 15. Percent of population under 18 years old | 16. Total population per household | 17. Percent of population under five years old | 18. Median age | 19. Percent of housing units with 1.01 persons or more per room | 20. School drop-out rate (corrected for migration) | 21. Suicide rate by place of residence | 22. Uniform crime rate - forcible rape | 23. Uniform crime rate - aggravated assault | 24. Disrupted marriage ratio |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Beaverhead | 43.59 | 46.00 | 25.07 | 29.40 | 43.05 | 59.20 | 36.12 | 50.70 | 55.04 | 45.48 | 60.38 | 77.01 |
| Big Horn | 79.44 | 87.61 | 67.14 | 80.90 | 61.87 | 32.54 | 80.66 | 59.70 | 41.54 | 45.48 | 48.28 | 51.94 |
| Blaine | 96.23 | 71.68 | 64.03 | 58.90 | 58.34 | 40.11 | 62.25 | 44.70 | 53.53 | 45.48 | 43.39 | 57.26 |
| Broadwater | 41.73 | 45.38 | 51.28 | 39.40 | 54.22 | 50.42 | 46.34 | 37.70 | 58.87 | 45.48 | 43.39 | 73.71 |
| Carbon | 48.66 | 45.63 | 37.83 | 36.40 | 31.87 | 71.02 | 33.84 | 38.70 | 47.37 | 45.80 | 49.26 | 41.65 |
| Carter | 48.59 | 45.63 | 47.83 | 48.90 | 46.58 | 49.20 | 57.71 | 60.70 | 41.54 | 50.01 | 49.99 | 61.06 |
| Cascade | 56.66 | 47.98 | 48.86 | 44.90 | 61.28 | 41.32 | 49.75 | 55.70 | 48.82 | 56.43 | 52.71 | 49.71 |
| Chouteau | 45.59 | 47.36 | 56.79 | 51.40 | 55.40 | 48.90 | 45.21 | 43.70 | 54.75 | 45.48 | 46.72 | 46.63 |
| Custer | 49.73 | 46.74 | 46.10 | 39.40 | 49.52 | 50.72 | 42.93 | 59.70 | 48.87 | 51.03 | 43.39 | 53.29 |
| Daniels | 45.44 | 45.51 | 49.90 | 48.90 | 47.75 | 51.63 | 42.71 | 49.70 | 41.54 | 45.48 | 49.89 | 43.59 |
| Dawson | 49.01 | 45.63 | 65.41 | 61.40 | 66.58 | 35.57 | 56.12 | 58.70 | 45.48 | 51.39 | 49.36 | 34.56 |
| Deer Lodge | 43.80 | 47.11 | 40.93 | 49.40 | 46.58 | 60.72 | 54.07 | 52.70 | 46.74 | 49.42 | 49.94 | 62.79 |
| Fallon | 43.44 | 45.51 | 59.90 | 56.40 | 61.87 | 40.11 | 58.84 | 59.70 | 41.54 | 45.48 | 49.50 | 38.23 |
| Fergus | 47.80 | 45.88 | 47.83 | 45.40 | 48.93 | 54.96 | 43.62 | 44.70 | 44.99 | 50.66 | 43.39 | 40.55 |
| Flathead | 50.51 | 46.25 | 48.52 | 45.90 | 47.16 | 54.66 | 44.30 | 59.70 | 50.38 | 58.77 | 49.33 | 43.17 |
| Gallatin | 43.59 | 45.88 | 35.41 | 42.40 | 47.75 | 37.99 | 39.07 | 47.70 | 45.28 | 48.25 | 44.32 | 41.01 |
| Garfield | 42.37 | 45.51 | 52.31 | 50.40 | 45.40 | 47.08 | 57.25 | 51.70 | 41.54 | 45.48 | 55.74 | 49.54 |
| Glacier | 75.59 | 92.05 | 67.14 | 73.90 | 70.11 | 32.54 | 75.21 | 65.70 | 41.54 | 58.11 | 47.62 | 56.50 |
| Golden Valley | 47.09 | 45.38 | 46.45 | 44.40 | 37.16 | 61.63 | 43.84 | 27.70 | 81.88 | 106.14 | 104.37 | 53.93 |
| Granite | 42.01 | 46.37 | 43.34 | 40.90 | 45.99 | 61.02 | 40.21 | 49.70 | 73.78 | 45.48 | 67.72 | 53.04 |
| Hill | 56.51 | 53.66 | 57.48 | 58.40 | 64.81 | 36.17 | 54.53 | 60.70 | 44.16 | 45.48 | 48.62 | 42.32 |
| Jefferson | 44.44 | 47.11 | 43.00 | 41.90 | 30.69 | 52.84 | 39.98 | 57.70 | 52.85 | 45.48 | 71.85 | 64.69 |
| Judith Basin | 44.16 | 45.88 | 49.55 | 45.90 | 46.58 | 55.87 | 38.39 | 49.70 | 41.54 | 45.48 | 43.39 | 52.53 |
| Lake | 54.51 | 59.46 | 49.90 | 51.90 | 44.22 | 56.17 | 49.98 | 36.70 | 41.54 | 45.48 | 43.39 | 44.90 |
| Lewis & Clark | 46.09 | 47.48 | 41.28 | 35.40 | 44.22 | 54.66 | 39.30 | 43.70 | 50.23 | 45.48 | 45.13 | 50.93 |
| Liberty | 44.30 | 45.88 | 62.66 | 64.40 | 63.64 | 38.60 | 56.34 | 31.70 | 41.54 | 45.48 | 43.39 | 43.63 |
| Lincoln | 50.51 | 45.88 | 59.90 | 57.40 | 59.52 | 38.60 | 59.53 | 61.70 | 53.15 | 57.16 | 45.35 | 47.43 |
| McCone | 54.51 | 45.51 | 60.93 | 65.40 | 57.16 | 43.75 | 58.16 | 36.70 | 41.54 | 45.48 | 43.39 | 37.93 |
| Madison | 43.87 | 46.62 | 40.59 | 33.90 | 35.40 | 66.17 | 37.71 | 31.70 | 41.54 | 45.48 | 57.47 | 52.79 |
| Meagher | 45.23 | 45.88 | 38.17 | 41.40 | 48.34 | 57.99 | 56.80 | 54.70 | 41.54 | 45.48 | 62.10 | 80.09 |
| Mineral | 49.23 | 46.12 | 58.86 | 55.40 | 53.05 | 40.42 | 54.30 | 55.70 | 73.53 | 45.48 | 51.44 | 52.49 |
| Missoula | 46.23 | 46.74 | 40.24 | 43.40 | 48.34 | 42.84 | 46.34 | 54.70 | 51.35 | 50.37 | 48.31 | 42.36 |
| Musselshell | 46.87 | 45.63 | 42.66 | 40.90 | 45.99 | 62.54 | 41.80 | 34.70 | 51.49 | 75.34 | 53.39 | 49.50 |
| Park | 45.66 | 45.88 | 38.17 | 36.40 | 39.52 | 60.11 | 42.03 | 47.70 | 52.61 | 45.48 | 47.11 | 50.30 |
| Petroleum | 41.80 | 46.12 | 36.79 | 46.90 | 35.40 | 61.63 | 42.48 | 48.70 | 41.54 | 45.48 | 43.39 | 50.89 |
| Phillips | 44.66 | 51.93 | 48.86 | 49.40 | 51.87 | 51.02 | 58.16 | 45.70 | 49.60 | 45.48 | 51.51 | 44.85 |
| Pondera | 48.73 | 54.64 | 63.00 | 66.40 | 57.75 | 38.60 | 54.30 | 48.70 | 41.54 | 55.04 | 43.39 | 47.01 |
| Powder River | 42.51 | 46.99 | 52.31 | 54.90 | 49.52 | 49.51 | 60.89 | 65.70 | 41.54 | 45.48 | 53.22 | 53.63 |
| Powell | 45.94 | 48.22 | 31.62 | 40.90 | 42.46 | 60.11 | 44.75 | 41.70 | 69.26 | 55.92 | 43.39 | 78.44 |
| Prairie | 43.51 | 46.25 | 54.72 | 44.90 | 42.46 | 47.69 | 49.53 | 53.70 | 41.54 | 76.94 | 43.39 | 50.25 |
| Ravalli | 46.37 | 46.25 | 41.28 | 39.40 | 34.22 | 65.87 | 43.39 | 46.70 | 53.34 | 45.48 | 45.37 | 39.79 |
| Richland | 51.30 | 45.88 | 59.29 | 56.40 | 56.58 | 42.84 | 54.98 | 53.70 | 41.54 | 45.48 | 43.39 | 35.06 |
| Roosevelt | 59.51 | 74.52 | 70.24 | 74.90 | 63.05 | 32.84 | 68.62 | 52.70 | 49.80 | 45.48 | 43.39 | 49.24 |
| Rosebud | 67.87 | 72.42 | 58.86 | 60.40 | 55.99 | 43.75 | 69.07 | 42.70 | 41.54 | 45.48 | 43.39 | 53.55 |
| Sanders | 52.87 | 52.79 | 40.24 | 35.90 | 41.87 | 60.72 | 49.98 | 61.70 | 48.58 | 45.48 | 43.39 | 56.12 |
| Sheridan | 53.51 | 46.12 | 51.97 | 54.40 | 47.16 | 51.93 | 42.48 | 48.70 | 56.59 | 45.48 | 47.18 | 36.17 |
| Silver Bow | 56.23 | 46.25 | 40.59 | 34.90 | 45.99 | 61.32 | 44.30 | 55.70 | 47.81 | 48.62 | 60.75 | 50.17 |
| Stillwater | 43.80 | 45.75 | 45.41 | 48.40 | 38.93 | 58.29 | 43.62 | 52.70 | 59.12 | 45.48 | 43.39 | 40.34 |
| Sweet Grass | 47.01 | 45.38 | 34.34 | 37.90 | 40.69 | 66.48 | 37.48 | 34.70 | 71.06 | 45.48 | 58.26 | 48.19 |
| Teton | 46.30 | 46.12 | 54.38 | 54.40 | 48.93 | 48.60 | 50.21 | 41.70 | 48.19 | 55.48 | 43.39 | 40.68 |
| Toole | 42.59 | 46.25 | 59.55 | 59.90 | 60.69 | 41.93 | 46.57 | 52.70 | 53.82 | 54.75 | 61.95 | 51.39 |
| Treasure | 56.30 | 45.51 | 62.31 | 62.90 | 65.40 | 37.69 | 58.16 | 80.70 | 77.61 | 45.48 | 43.39 | 52.24 |
| Valley | 46.51 | 51.43 | 57.83 | 61.90 | 71.87 | 34.35 | 64.53 | 52.70 | 47.22 | 45.48 | 43.39 | 43.59 |
| Wheatland | 44.30 | 46.25 | 40.24 | 38.90 | 37.75 | 63.75 | 42.48 | 46.70 | 41.54 | 45.48 | 43.39 | 47.05 |
| Wibaux | 52.30 | 45.51 | 58.17 | 56.90 | 48.93 | 48.90 | 47.03 | 41.70 | 41.54 | 45.48 | 57.79 | 46.50 |
| Yellowstone | 52.94 | 46.62 | 52.66 | 48.40 | 53.64 | 44.05 | 41.80 | 52.70 | 51.98 | 52.85 | 45.86 | 43.29 |

| | 25. Per capita state and county expenditures for Old Age Assistance | 26. Percent unemployed | 27. Mean personal income | 28. Percent of housing units without plumbing facilities | 29. Male first admission rate to State Prison | 30. First admission rate to the Girls' Vocational School | 31. First admission rate to the Boys' Industrial School | 32. Mileage from county seat to Montana State Hospital | 33. Percent population increase 1950-1960 | 34. Percent of population age 65 and above | 35. Percent of male population age 19-34 | 36. Population over age five living in same house in 1960 as in 1955 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Beaverhead | 57.48 | 48.88 | 45.75 | 54.05 | 56.35 | 51.83 | 46.20 | 37.52 | 50.55 | 54.18 | 57.23 | 43.31 |
| Big Horn | 49.94 | 63.12 | 39.82 | 60.55 | 45.94 | 56.07 | 47.23 | 52.41 | 46.99 | 36.35 | 53.68 | 46.80 |
| Blaine | 58.94 | 54.64 | 42.61 | 66.18 | 57.83 | 70.93 | 73.03 | 52.41 | 42.84 | 50.27 | 44.65 | 51.10 |
| Broadwater | 44.32 | 42.21 | 44.71 | 51.43 | 41.49 | 56.07 | 38.98 | 39.25 | 43.44 | 54.18 | 39.81 | 54.13 |
| Carbon | 63.86 | 44.33 | 41.28 | 46.86 | 50.40 | 41.21 | 50.33 | 59.95 | 34.52 | 69.40 | 34.65 | 59.71 |
| Carter | 80.55 | 42.82 | 48.47 | 68.13 | 35.54 | 41.21 | 45.17 | 66.76 | 39.28 | 48.96 | 54.00 | 60.41 |
| Cascade | 39.48 | 51.91 | 61.44 | 41.33 | 48.92 | 58.20 | 47.23 | 43.44 | 69.04 | 37.66 | 70.45 | 34.24 |
| Chouteau | 39.25 | 38.58 | 69.54 | 44.15 | 45.94 | 41.21 | 45.17 | 46.10 | 49.10 | 50.27 | 43.04 | 64.71 |
| Custer | 50.78 | 51.30 | 50.86 | 38.51 | 56.35 | 53.95 | 56.52 | 58.92 | 48.56 | 55.48 | 53.04 | 40.99 |
| Daniels | 44.40 | 44.33 | 41.93 | 55.50 | 40.00 | 41.21 | 38.98 | 68.49 | 42.96 | 54.18 | 44.00 | 62.27 |
| Dawson | 39.32 | 45.55 | 58.26 | 39.68 | 50.40 | 53.95 | 63.75 | 63.97 | 67.17 | 36.35 | 57.55 | 43.66 |
| Deer Lodge | 33.25 | 50.39 | 49.15 | 40.84 | 45.94 | 51.83 | 49.30 | 32.87 | 53.44 | 48.09 | 43.04 | 53.90 |
| Fallon | 52.55 | 43.73 | 47.15 | 50.17 | 59.32 | 41.21 | 38.98 | 64.37 | 51.39 | 42.87 | 58.84 | 50.99 |
| Fergus | 55.78 | 42.52 | 50.38 | 42.11 | 47.43 | 73.06 | 68.91 | 49.75 | 45.85 | 63.31 | 45.29 | 53.20 |
| Flathead | 45.94 | 74.94 | 50.35 | 42.20 | 45.94 | 47.58 | 54.46 | 47.62 | 48.68 | 53.74 | 44.33 | 46.69 |
| Gallatin | 37.25 | 43.42 | 45.82 | 40.17 | 45.94 | 45.46 | 42.07 | 39.58 | 57.23 | 42.87 | 84.33 | 34.59 |
| Garfield | 52.02 | 44.64 | 39.05 | 70.26 | 55.38 | 41.21 | 38.98 | 58.39 | 40.55 | 52.44 | 49.49 | 57.85 |
| Glacier | 52.25 | 71.91 | 49.08 | 53.56 | 51.89 | 66.69 | 57.55 | 50.08 | 57.84 | 29.83 | 60.13 | 41.22 |
| Golden Valley | 58.25 | 40.09 | 51.99 | 59.97 | 35.54 | 41.21 | 38.98 | 47.82 | 39.82 | 67.22 | 38.20 | 70.29 |
| Granite | 44.17 | 65.24 | 47.32 | 71.91 | 41.49 | 41.21 | 38.98 | 34.80 | 51.09 | 51.13 | 43.36 | 49.83 |
| Hill | 39.25 | 52.21 | 75.20 | 41.62 | 65.26 | 66.69 | 74.07 | 50.95 | 64.28 | 39.83 | 64.33 | 42.03 |
| Jefferson | 49.32 | 42.21 | 43.36 | 45.70 | 51.89 | 41.21 | 45.17 | 35.73 | 50.13 | 46.79 | 52.39 | 50.06 |
| Judith Basin | 64.32 | 37.97 | 60.79 | 43.37 | 40.00 | 41.21 | 38.98 | 47.56 | 43.68 | 49.83 | 41.42 | 60.17 |
| Lake | 52.09 | 60.70 | 34.68 | 48.13 | 42.97 | 51.83 | 60.65 | 44.44 | 42.66 | 62.00 | 37.55 | 46.80 |
| Lewis & Clark | 39.17 | 48.27 | 57.50 | 41.52 | 57.83 | 58.20 | 61.68 | 37.13 | 54.34 | 56.72 | 51.10 | 38.90 |
| Liberty | 32.55 | 48.58 | 89.50 | 42.98 | 48.92 | 58.20 | 52.39 | 51.41 | 58.14 | 31.57 | 56.58 | 49.01 |
| Lincoln | 42.55 | 85.55 | 54.15 | 59.97 | 56.35 | 49.70 | 63.75 | 53.54 | 72.48 | 35.92 | 57.87 | 42.03 |
| McCone | 41.25 | 44.94 | 45.60 | 51.33 | 38.51 | 41.21 | 38.98 | 62.84 | 46.99 | 46.79 | 49.16 | 65.64 |
| Madison | 68.78 | 43.92 | 40.09 | 56.38 | 44.46 | 41.21 | 38.98 | 38.59 | 37.96 | 62.87 | 38.20 | 55.99 |
| Meagher | 69.48 | 57.67 | 47.11 | 71.33 | 90.52 | 41.21 | 53.43 | 42.11 | 61.39 | 52.00 | 49.81 | 34.13 |
| Mineral | 50.17 | 61.00 | 60.77 | 46.48 | 48.92 | 41.21 | 43.11 | 43.77 | 73.50 | 35.92 | 49.81 | 26.22 |
| Missoula | 38.86 | 56.76 | 53.90 | 36.57 | 40.00 | 49.70 | 46.20 | 39.92 | 61.39 | 44.18 | 69.81 | 32.27 |
| Musselshell | 55.02 | 44.64 | 48.38 | 49.00 | 72.69 | 75.18 | 47.23 | 50.55 | 40.07 | 66.35 | 39.81 | 56.22 |
| Park | 43.32 | 56.45 | 48.09 | 44.24 | 63.77 | 43.33 | 47.23 | 41.25 | 51.69 | 55.48 | 48.84 | 43.66 |
| Petroleum | 50.40 | 38.88 | 49.57 | 76.38 | 45.94 | 41.21 | 57.55 | 53.27 | 38.08 | 52.44 | 50.13 | 69.24 |
| Phillips | 58.25 | 46.15 | 42.80 | 56.48 | 66.75 | 68.81 | 50.33 | 56.93 | 42.96 | 61.57 | 50.13 | 56.22 |
| Pondera | 44.02 | 43.73 | 50.12 | 40.07 | 42.97 | 41.21 | 45.17 | 46.89 | 57.72 | 40.27 | 52.71 | 51.92 |
| Powder River | 44.48 | 37.36 | 59.01 | 59.49 | 35.54 | 41.21 | 38.98 | 60.51 | 41.21 | 46.35 | 51.42 | 55.76 |
| Powell | 47.40 | 44.94 | 49.50 | 47.45 | 42.97 | 53.95 | 58.59 | 33.41 | 52.54 | 46.79 | 60.78 | 41.22 |
| Prairie | 58.17 | 41.61 | 43.51 | 46.18 | 40.00 | 41.21 | 45.17 | 61.51 | 44.34 | 52.44 | 46.58 | 61.45 |
| Ravalli | 63.32 | 53.73 | 38.41 | 42.50 | 42.97 | 47.58 | 56.52 | 42.44 | 42.35 | 67.66 | 36.91 | 47.85 |
| Richland | 49.94 | 56.76 | 44.61 | 48.81 | 53.37 | 45.46 | 54.46 | 67.43 | 46.63 | 50.27 | 47.23 | 50.17 |
| Roosevelt | 46.02 | 59.79 | 45.10 | 55.41 | 51.89 | 73.06 | 72.00 | 64.90 | 59.40 | 45.05 | 50.13 | 52.03 |
| Rosebud | 66.25 | 53.42 | 40.49 | 57.25 | 60.80 | 58.20 | 63.75 | 56.00 | 42.35 | 49.40 | 44.00 | 50.87 |
| Sanders | 66.32 | 63.42 | 46.28 | 53.56 | 48.92 | 41.21 | 38.98 | 46.63 | 44.95 | 62.00 | 43.36 | 48.55 |
| Sheridan | 51.09 | 49.79 | 42.97 | 52.20 | 41.49 | 41.21 | 38.98 | 71.28 | 43.92 | 56.79 | 45.29 | 70.64 |
| Silver Bow | 46.17 | 59.48 | 51.61 | 42.59 | 47.43 | 60.32 | 62.71 | 33.94 | 43.38 | 52.00 | 43.68 | 58.31 |
| Stillwater | 48.32 | 39.79 | 45.75 | 51.14 | 53.37 | 41.21 | 38.98 | 46.36 | 47.05 | 55.92 | 40.13 | 51.45 |
| Sweet Grass | 57.40 | 47.36 | 42.06 | 38.51 | 50.40 | 41.21 | 61.68 | 43.64 | 40.37 | 70.27 | 46.91 | 47.85 |
| Teton | 44.78 | 39.79 | 54.06 | 45.50 | 41.49 | 47.58 | 53.43 | 44.04 | 46.39 | 47.66 | 44.97 | 59.83 |
| Toole | 36.40 | 49.79 | 71.60 | 40.46 | 40.00 | 56.07 | 41.04 | 48.62 | 54.95 | 38.09 | 51.42 | 45.17 |
| Treasure | 55.71 | 43.42 | 46.18 | 61.14 | 60.80 | 41.21 | 38.98 | 54.27 | 43.38 | 43.31 | 52.07 | 43.43 |
| Valley | 38.94 | 58.88 | 55.21 | 42.11 | 57.83 | 53.95 | 49.30 | 61.64 | 76.21 | 32.44 | 81.10 | 31.34 |
| Wheatland | 53.02 | 37.36 | 50.57 | 32.98 | 60.80 | 53.95 | 50.33 | 45.90 | 42.78 | 62.44 | 38.52 | 48.31 |
| Wibaux | 51.71 | 35.24 | 33.22 | 46.96 | 42.97 | 41.21 | 38.98 | 65.96 | 39.22 | 53.31 | 41.10 | 59.01 |
| Yellowstone | 36.17 | 52.82 | 63.29 | 36.67 | 53.37 | 53.95 | 51.36 | 49.09 | 70.79 | 36.35 | 55.62 | 36.34 |

| | 37. Percent of housing units in structures built in 1950 or later | 38. Per capita expenditure for liquor | 39. Age adjusted 1st admission rate to M.S.H. adjusted for effect of distance from county to hospital | 40. Age adjusted 1st admission rate to mental hygiene clinics | 41. Per capita state and county expenditures for Aid to Permanently and Totally Disabled |
|---|---|---|---|---|---|
| Beaverhead | 48.27 | 70.86 | 53.50 | 46.02 | 49.22 |
| Big Horn | 48.18 | 42.62 | 41.70 | 43.77 | 60.22 |
| Blaine | 42.06 | 50.71 | 70.80 | 44.52 | 60.22 |
| Broadwater | 42.87 | 50.86 | 28.30 | 55.77 | 46.72 |
| Carbon | 40.53 | 44.77 | 73.60 | 43.54 | 68.47 |
| Carter | 49.08 | 45.86 | 47.70 | 43.02 | 45.48 |
| Cascade | 59.99 | 57.30 | 42.50 | 55.02 | 57.48 |
| Chouteau | 46.47 | 46.58 | 43.50 | 48.27 | 46.72 |
| Custer | 47.82 | 53.83 | 51.00 | 45.27 | 46.48 |
| Daniels | 44.85 | 41.73 | 63.80 | 43.02 | 58.48 |
| Dawson | 58.09 | 46.07 | 44.10 | 43.77 | 40.73 |
| Deer Lodge | 47.82 | 50.62 | 60.20 | 52.02 | 49.72 |
| Fallon | 49.90 | 44.51 | 58.40 | 45.27 | 42.97 |
| Fergus | 46.29 | 48.45 | 55.50 | 45.27 | 55.73 |
| Flathead | 53.05 | 49.00 | 61.60 | 50.52 | 52.48 |
| Gallatin | 49.81 | 46.68 | 39.00 | 45.27 | 41.22 |
| Garfield | 113.50 | 39.64 | 59.40 | 44.52 | 43.97 |
| Glacier | 50.71 | 80.27 | 56.70 | 45.27 | 58.98 |
| Golden Valley | 37.28 | 43.02 | 32.70 | 43.02 | 33.97 |
| Granite | 43.95 | 58.69 | 44.80 | 56.52 | 47.47 |
| Hill | 57.46 | 56.91 | 50.70 | 47.52 | 44.48 |
| Jefferson | 41.70 | 40.86 | 46.70 | 55.77 | 42.73 |
| Judith Basin | 44.94 | 47.91 | 38.70 | 45.27 | 40.47 |
| Lake | 50.17 | 41.52 | 46.70 | 55.02 | 54.23 |
| Lewis & Clark | 50.80 | 68.39 | 56.30 | 89.53 | 42.97 |
| Liberty | 54.67 | 54.07 | 54.20 | 46.02 | 42.97 |
| Lincoln | 63.14 | 40.43 | 43.70 | 52.77 | 44.23 |
| McCone | 53.23 | 33.64 | 53.00 | 43.02 | 37.47 |
| Madison | 44.13 | 49.89 | 62.10 | 51.27 | 49.22 |
| Meagher | 53.41 | 65.00 | 61.30 | 46.02 | 66.22 |
| Mineral | 63.68 | 67.70 | 43.50 | 62.52 | 40.98 |
| Missoula | 56.65 | 49.93 | 48.70 | 90.28 | 41.72 |
| Musselshell | 40.71 | 58.73 | 49.50 | 58.02 | 58.73 |
| Park | 46.29 | 54.93 | 64.40 | 43.77 | 53.23 |
| Petroleum | 38.72 | 38.14 | 52.10 | 43.02 | 33.97 |
| Phillips | 42.60 | 48.02 | 52.10 | 45.27 | 45.23 |
| Pondera | 51.16 | 51.97 | 43.50 | 49.02 | 43.48 |
| Powder River | 47.37 | 31.48 | 35.60 | 44.52 | 36.22 |
| Powell | 51.61 | 53.51 | 41.90 | 46.77 | 67.72 |
| Prairie | 38.99 | 33.92 | 51.30 | 52.77 | 54.48 |
| Ravalli | 46.47 | 34.62 | 47.70 | 70.02 | 59.22 |
| Richland | 49.63 | 39.69 | 54.80 | 46.02 | 50.73 |
| Roosevelt | 55.03 | 59.50 | 62.00 | 43.69 | 59.22 |
| Rosebud | 45.39 | 57.44 | 54.20 | 44.52 | 56.73 |
| Sanders | 52.87 | 48.56 | 41.10 | 68.52 | 71.47 |
| Sheridan | 44.22 | 46.19 | 45.90 | 43.02 | 51.48 |
| Silver Bow | 40.17 | 67.96 | 65.00 | 62.52 | 65.22 |
| Stillwater | 43.68 | 38.45 | 45.90 | 45.27 | 48.97 |
| Sweet Grass | 46.38 | 55.58 | 58.10 | 44.52 | 52.73 |
| Teton | 45.93 | 44.04 | 31.00 | 48.27 | 57.23 |
| Toole | 52.96 | 67.00 | 53.10 | 45.27 | 42.97 |
| Treasure | 48.72 | 40.22 | 35.40 | 46.77 | 37.22 |
| Valley | 65.30 | 51.81 | 42.30 | 43.02 | 49.22 |
| Wheatland | 41.61 | 53.29 | 55.00 | 43.02 | 57.23 |
| Wibaux | 45.66 | 51.46 | 26.20 | 43.02 | 42.97 |
| Yellowstone | 64.04 | 56.37 | 53.10 | 55.02 | 49.72 |

TABLE 3

MONTANA POPULATION 1960
AND
ESTIMATED POPULATIONS 1961-1963
BY AGE

| AGE GROUPS | U.S. CENSUS[1] | POPULATION ESTIMATES[2] | | |
|---|---|---|---|---|
| | | 1961 | 1962 | 1963 |
| 0 - 4 | 83,102 | 84,138 | 87,588 | 87,406 |
| 5 - 9 | 77,048 | 77,864 | 80,980 | 80,758 |
| 10 - 14 | 67,042 | 67,711 | 70,370 | 70,155 |
| 15 - 19 | 50,767 | 51,322 | 53,343 | 53,190 |
| 20 - 24 | 39,578 | 40,207 | 41,880 | 41,846 |
| 25 - 29 | 38,882 | 39,390 | 41,009 | 40,961 |
| 30 - 34 | 41,729 | 42,219 | 43,909 | 43,818 |
| 35 - 39 | 42,773 | 43,242 | 44,955 | 44,838 |
| 40 - 44 | 43,202 | 43,699 | 45,404 | 45,256 |
| 45 - 49 | 39,939 | 40,331 | 41,883 | 41,740 |
| 50 - 54 | 33,335 | 33,616 | 34,906 | 34,782 |
| 55 - 59 | 28,492 | 28,717 | 29,816 | 29,697 |
| 60 - 64 | 23,458 | 23,713 | 24,511 | 24,409 |
| 65 - 69 | 22,797 | 22,878 | 23,858 | 23,756 |
| 70 - 74 | 20,199 | 20,355 | 21,124 | 21,028 |
| 75 & over | 22,424 | 22,598 | 23,464 | 23,306 |
| TOTALS | 674,767 | 682,000 | 709,000 | 707,000 |

TABLE 4

POPULATION OF MONTANA COUNTIES
1960

| | | | |
|---|---|---|---|
| Beaverhead | 7,194 | Madison | 5,211 |
| Big Horn | 10,007 | Meagher | 2,616 |
| Blaine | 8,091 | Mineral | 3,037 |
| Broadwater | 2,804 | Missoula | 44,663 |
| Carbon | 8,317 | Musselshell | 4,888 |
| Carter | 2,493 | Park | 13,168 |
| Cascade | 73,418 | Petroleum | 894 |
| Chouteau | 7,348 | Phillips | 6,027 |
| Custer | 13,227 | Pondera | 7,653 |
| Daniels | 3,755 | Powder River | 2,485 |
| Dawson | 12,314 | Powell | 7,002 |
| Deer Lodge | 18,640 | Prairie | 2,318 |
| Fallon | 3,997 | Ravalli | 12,341 |
| Fergus | 14,018 | Richland | 10,504 |
| Flathead | 32,965 | Roosevelt | 11,731 |
| Gallatin | 26,045 | Rosebud | 6,187 |
| Garfield | 1,981 | Sanders | 6,880 |
| Glacier | 11,565 | Sheridan | 6,458 |
| Golden Valley | 1,203 | Silver Bow | 46,454 |
| Granite | 3,014 | Stillwater | 5,526 |
| Hill | 18,653 | Sweet Grass | 3,290 |
| Jefferson | 4,297 | Teton | 7,295 |
| Judith Basin | 3,085 | Toole | 7,904 |
| Lake | 13,104 | Treasure | 1,345 |
| Lewis & Clark | 28,006 | Valley | 17,080 |
| Liberty | 2,624 | Wheatland | 3,026 |
| Lincoln | 12,537 | Wibaux | 1,698 |
| McCone | 3,321 | Yellowstone | 79,016 |
| | | Yellowstone National Park | 47 |

SOURCE: U.S., Bureau of the Census, U.S. Census of Population: 1960, Number of Inhabitants, Montana, Final Report PC (1)-28A, p. 28-11.

# APPENDIX B

# FEDERAL LAWS AND REGULATIONS

Public Law 88-164
88th Congress, S. 1576
October 31, 1963

# An Act

To provide assistance in combating mental retardation through grants for construction of research centers and grants for facilities for the mentally retarded and assistance in improving mental health through grants for construction of community mental health centers, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled*, That this Act may be cited as the "Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963".

## TITLE I—CONSTRUCTION OF RESEARCH CENTERS AND FACILITIES FOR THE MENTALLY RETARDED

* * *

## TITLE II—CONSTRUCTION OF COMMUNITY MENTAL HEALTH CENTERS

### SHORT TITLE

SEC. 200. This title may be cited as the "Community Mental Health Centers Act".

### AUTHORIZATION OF APPROPRIATIONS

SEC. 201. There are authorized to be appropriated, for grants for construction of public and other nonprofit community mental health centers, $35,000,000 for the fiscal year ending June 30, 1965, $50,000,000 for the fiscal year ending June 30, 1966, and $65,000,000 for the fiscal year ending June 30, 1967.

### ALLOTMENTS TO STATES

SEC. 202. (a) For each fiscal year, the Secretary shall, in accordance with regulations, make allotments from the sums appropriated under section 201 to the several States on the basis of (1) the population, (2) the extent of the need for community mental health centers, and (3) the financial need of the respective States; except that no such allotment to any State, other than the Virgin Islands, American Samoa, and Guam, for any fiscal year may be less than $100,000. Sums so allotted to a State for a fiscal year and remaining unobligated at the end of such year shall remain available to such State for such purpose for the next fiscal year (and for such year only), in addition to the sums allotted for such State for such next fiscal year.

(b) In accordance with regulations of the Secretary, any State may file with him a request that a specified portion of its allotment under this title be added to the allotment of another State under this title for the purpose of meeting a portion of the Federal share of the cost of a project for the construction of a community mental health center in such other State. If it is found by the Secretary that construction of the center with respect to which the request is made would meet needs of the State making the request and that use of the specified portion of such State's allotment, as requested by it, would assist in carrying out the purposes of this title, such portion of such State's allotment shall be added to the allotment of the other State under this title to be used for the purpose referred to above.

(c) Upon the request of any State that a specified portion of its allotment under this title be added to the allotment of such State under part C of title I and upon (1) the simultaneous certification to the Secretary by the State agency designated as provided in the State plan approved under this title to the effect that it has afforded a reasonable opportunity to make applications for the portion so specified and there have been no approvable applications for such

portion or (2) a showing satisfactory to the Secretary that the need for facilities for the mentally retarded in such State is substantially greater than for community mental health centers, the Secretary shall, subject to such limitations as he may by regulation prescribe, promptly adjust the allotments of such State in accordance with such request and shall notify such State agency and the State agency designated under the State plan approved under part C of title I, and thereafter the allotments as so adjusted shall be deemed the State's allotments for purposes of this title and part C of title I.

REGULATIONS

SEC. 203. Within six months after enactment of this Act, the Secretary shall, after consultation with the Federal Hospital Council (established by section 633 of the Public Health Service Act) and the National Advisory Mental Health Council (established by section 217 of the Public Health Service Act), by general regulations applicable uniformly to all the States, prescribe—

(1) the kinds of community mental health services needed to provide adequate mental health services for persons residing in a State;

(2) the general manner in which the State agency (designated as provided in the State plan approved under this title) shall determine the priority of projects based on the relative need of different areas, giving special consideration to projects on the basis of the extent to which the centers to be constructed thereby will, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, provide comprehensive mental health services (as determined by the Secretary in accordance with regulations) for mentally ill persons in a particular community or communities or which will be part of or closely associated with a general hospital;

(3) general standards of construction and equipment for centers of different classes and in different types of location; and

(4) that the State plan shall provide for adequate community mental health centers for people residing in the State, and shall provide for adequate community mental health centers to furnish needed services for persons unable to pay therefor. Such regulations may require that before approval of an application for a center or addition to a center is recommended by a State agency, assurance shall be received by the State from the applicant that there will be made available in such center or addition a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.

STATE PLANS

SEC. 204. (a) After such regulations have been issued, any State desiring to take advantage of this title shall submit a State plan for carrying out its purposes. Such State plan must—

(1) designate a single State agency as the sole agency for the administration of the plan, or designate such agency as the sole agency for supervising the administration of the plan;

(2) contain satisfactory evidence that the State agency designated in accordance with paragraph (1) hereof will have authority to carry out such plan in conformity with this title;

(3) provide for the designation of a State advisory council which shall include representatives of nongovernment organizations or groups, and of State agencies, concerned with planning, operation, or utilization of community mental health centers or other mental health facilities, including representatives of consumers of the services provided by such centers and facilities who are familiar with the need for such services, to consult with the State agency in carrying out such plan;

(4) set forth a program for construction of community mental health centers (A) which is based on a statewide inventory of

existing facilities and survey of need; (B) which conforms with the regulations prescribed by the Secretary under section 203(1); and (C) which meets the requirements for furnishing needed services to persons unable to pay therefor, included in regulations prescribed under section 203(4);

(5) set forth the relative need, determined in accordance with the regulations prescribed under section 203(2), for the several projects included in such programs, and provide for the construction, insofar as financial resources available therefor and for maintenance and operation make possible, in the order of such relative need;

(6) provide such methods of administration of the State plan, including methods relating to the establishment and maintenance of personnel standards on a merit basis (except that the Secretary shall exercise no authority with respect to the selection, tenure of office, or compensation of any individual employed in accordance with such methods), as are found by the Secretary to be necessary for the proper and efficient operation of the plan;

(7) provide minimum standards (to be fixed in the discretion of the State) for the maintenance and operation of centers which receive Federal aid under this title;

(8) provide for affording to every applicant for a construction project an opportunity for hearing before the State agency;

(9) provide that the State agency will make such reports in such form and containing such information as the Secretary may from time to time reasonably require, and will keep such records and afford such access thereto as the Secretary may find necessary to assure the correctness and verification of such reports; and

(10) provide that the State agency will from time to time, but not less often than annually, review its State plan and submit to the Secretary any modifications thereof which it considers necessary.

(b) The Secretary shall approve any State plan and any modification thereof which complies with the provisions of subsection (a). The Secretary shall not finally disapprove a State plan except after reasonable notice and opportunity for a hearing to the State.

APPROVAL OF PROJECTS

SEC. 205. (a) For each project for construction pursuant to a State plan approved under this title, there shall be submitted to the Secretary through the State agency an application by the State or a political subdivision thereof or by a public or other nonprofit agency. If two or more such agencies join in the construction of the project, the application may be filed by one or more of such agencies. Such application shall set forth—

(1) a description of the site for such project;

(2) plans and specifications therefor in accordance with the regulations prescribed by the Secretary under section 203(3);

(3) reasonable assurance that title to such site is or will be vested in one or more of the agencies filing the application or in a public or other nonprofit agency which is to operate the community mental health center;

(4) reasonable assurance that adequate financial support will be available for the construction of the project and for its maintenance and operation when completed;

(5) reasonable assurance that all laborers and mechanics employed by contractors or subcontractors in the performance of work on construction of the project will be paid wages at rates not less than those prevailing on similar construction in the

locality as determined by the Secretary of Labor in accordance with the Davis-Bacon Act, as amended (40 U.S.C. 276a—276a–5); and the Secretary of Labor shall have with respect to the labor standards specified in this paragraph the authority and functions set forth in Reorganization Plan Numbered 14 of 1950 (15 F.R. 3176; 5 U.S.C. 133z–15) and section 2 of the Act of June 13, 1934, as amended (40 U.S.C. 276c); and

(6) a certification by the State agency of the Federal share for the project.

The Secretary shall approve such application if sufficient funds to pay the Federal share of the cost of construction of such project are available from the allotment to the State, and if the Secretary finds (A) that the application contains such reasonable assurance as to title, financial support, and payment of prevailing rates of wages and overtime pay; (B) that the plans and specifications are in accord with the regulations prescribed pursuant to section 203; (C) that the application is in conformity with the State plan approved under section 204 and contains an assurance that in the operation of the center there will be compliance with the applicable requirements of the State plan and of the regulations prescribed under section 203(4) for furnishing needed services for persons unable to pay therefor, and with State standards for operation and maintenance; (D) that the services to be provided by the center, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, will be part of a program providing, principally for persons residing in a particular community or communities in or near which such center is to be situated, at least those essential elements of comprehensive mental health services for mentally ill persons which are prescribed by the Secretary in accordance with regulations; and (E) that the application has been approved and recommended by the State agency and is entitled to priority over other projects within the State in accordance with the regulations prescribed pursuant to section 203(2). No application shall be disapproved by the Secretary until he has afforded the State agency an opportunity for a hearing.

(b) Amendment of any approved application shall be subject to approval in the same manner as an original application.

WITHHOLDING OF PAYMENTS

SEC. 206. Whenever the Secretary, after reasonable notice and opportunity for hearing to the State agency designated as provided in section 204(a)(1), finds—

(1) that the State agency is not complying substantially with the provisions required by section 204 to be included in its State plan, or with regulations under this title;

(2) that any assurance required to be given in an application filed under section 205 is not being or cannot be carried out;

(3) that there is a substantial failure to carry out plans and specifications approved by the Secretary under section 205; or

(4) that adequate State funds are not being provided annually for the direct administration of the State plan,

the Secretary may forthwith notify the State agency that—

(5) no further payments will be made to the State from allotments under this title; or

(6) no further payments will be made from allotments under this title for any project or projects designated by the Secretary as being affected by the action or inaction referred to in paragraph (1), (2), (3), or (4) of this section,

as the Secretary may determine to be appropriate under the circumstances; and, except with regard to any project for which the application has already been approved and which is not directly affected, further payments from such allotments may be withheld, in whole or in part, until there is no longer any failure to comply (or to carry out the assurance or plans and specifications or to provide adequate State funds, as the case may be) or, if such compliance (or other action) is impossible, until the State repays or arranges for the repayment of Federal moneys to which the recipient was not entitled.

NONDUPLICATION OF GRANTS

SEC. 207. No grant may be made after January 1, 1964, under any provision of the Public Health Service Act, for any of the three fiscal years in the period beginning July 1, 1964, and ending June 30, 1967, for construction of any facility described in this title, unless the Secretary determines that funds are not available under this title to make a grant for the construction of such facility.

## TITLE III—TRAINING OF TEACHERS OF MENTALLY RETARDED AND OTHER HANDICAPPED CHILDREN

* * *

## TITLE IV—GENERAL

* * *

COMMUNITY MENTAL HEALTH CENTERS ACT OF 1963

Title II
Public Law 88-164

Regulations

Reprinted from the FEDERAL REGISTER, May 6, 1964

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service

## PART 54—GRANTS FOR CONSTRUCTION OF SPECIALIZED SERVICE FACILITIES

### Subpart C—Grants for Construction of Community Mental Health Centers

Notice of proposed rule making, public rule-making procedures and postponement of effecting date have been omitted in the issuance of the following Subpart C—Grants for Construction of Community Mental Health Centers of new Part 54—Grants for Construction of Specialized Service Facilities, which relates solely to grants for construction of public and other nonprofit facilities for the mentally ill. These regulations shall become effective on the date of publication in the FEDERAL REGISTER.

Sec.

54.201 Definitions.
54.202 Allotments; transfer of allotments.
54.203 State plan; elements of adequate services; facilities; relationship to other planning.
54.204 State plan; areas; determination of relative need; priorities.
54.205 State plan; methods of administration.
54.206 State plant; processing of appli tions.
54.207 State plan; construction progra design of facilities; minim standards of maintenance a operation.
54.208 State plan; requests for constr tion payments; fiscal and accou ing requirements.
54.209 State plan; assurances from ap cant.
54.210 State plan; community service; n discrimination; services for p sons unable to pay.
54.211 State plan; approval and certifi tion of application.
54.212 Projects; essential elements of cc prehensive mental health servic program requirements.
54.213 Change of status of facility.
54.214 Good cause for other use of facil
54.215 Appendix A—General standards construction and equipment.

AUTHORITY: The provisions of this Subp C issued under sec. 203, 77 Stat. 291; 42 U.S 2683. Interpret or apply secs. 200 to 2 401 to 407, 77 Stat. 290 to 294, 296 to 2 42 U.S.C. 2681 to 2687, 2691 to 2696.

**§ 54.201 Definitions.**

As used in this subpart all terms defined herein shall have the sa meaning as indicated in the Act.

(a) "Act" means the Mental Ret dation Facilities and Community Mer Health Centers Construction Act of 1 (Pub. Law 88-164)

(b) "Area" means the geographic t ritory which includes one or more co munities served or to be served by ex ing or proposed community mer health facilities, the delineation of wh is based on such factors as populat distribution, natural geographic bou aries, and transportation accessibil Nothing in the regulations in this s part shall preclude the formation of interstate area with the mutual agr ment of the States concerned.

(c) "Community" means an area that portion of an area served or to served by a program providing at le the essential elements of comprehen mental health services as specified § 54.212.

(d) "Community mental health cility" means a community mental hea center (as defined in section 401(c) the Act) for the provision of serv which, either alone or in conjunct with other facilities owned or opera by the applicant or affiliated or ass ated with the applicant, will be part a program providing, principally for sons residing in a particular commu or communities in or near which center is situated, at least those ess tial elements of comprehensive me health services that are prescribed § 54.212.

(e) "Community service" mean the services to be furnished by a gram providing at least the essen elements of comprehensive mental he services will be available to the ge public.

(f) "Comprehensive mental he planning" means the planning o statewide basis for the provision of quate mental health services, taking consideration such factors as probl of availability of manpower and fa

the role of mental hospitals, the development of new improved methods for the treatment or prevention of mental illness, and laws applicable to the mentally ill.

(b) "Comprehensive mental health services" means a complete range of all the elements of service specified in § 54.203(a) in sufficient quantity to meet the needs of persons residing within the community served by a community mental health facility, taking into consideration factors such as the age group served, diagnostic categories treated, and the availability of short, medium and long term care.

(c) "Elements of service" means the individual types of mental health service prescribed in § 54.203(a).

(d) "Essential elements of comprehensive mental health services" means the elements of service prescribed in § 54.212(a).

(e) "Equipment" means those items which are necessary for the functioning of the facility, and which are considered depreciable and as having an estimated life of not less than five years. Not included are items of current operating expense such as glassware, chemicals, and fuel.

(f) "Program" means the existence of and the administrative and working relationships between at least the essential elements of comprehensive mental health services to be provided to a community served by a community mental health facility which meets the criteria of § 54.212.

(g) "Population" means the latest figures of total population residing in the States as certified by the Federal Department of Commerce.

(h) "Surgeon General" means the Surgeon General of the Public Health Service.

(i) "Title II of the Act" means the "Community Mental Health Centers Act" (Title II, Pub. Law 88–164).

**§ 54.202 Allotments; transfer of allotments.**

(a) *Allotments to States.* The allotments to the several States under Title II of the Act shall be computed as follows:

(1) One-third on the basis of a factor weighted by the relationship of the total population in each State to the total population of the United States.

(2) Two-thirds on the basis of total population weighted by financial need. "Financial need" as applied to any State means the relative per capita income as shown by data supplied by the Federal Department of Commerce for the three most recent consecutive years for which satisfactory data are available.

(b) *Transfer of allotment to another State.* A State may submit a request in writing to the Surgeon General that its allotment or a specified portion thereof be added to the allotment of another State for the purpose of meeting a portion of the Federal share of the cost of a project for the construction of a community mental health facility in such other State. In determining whether the facility with respect to which the request is made will meet the needs of the State making the request and that use of the specified portion of such State's allotment, as requested by it, will assist in carrying out the purposes of Title II of the Act, the Surgeon General shall consider the accessibility of the facility and the extent to which services will be made available to the residents of the State making the request.

(c) *Transfer of allotment to the allotment for facilities for the mentally retarded.* A State may submit a request in writing to the Surgeon General that a specified portion of its allotment be added to the allotment to such State for the construction of facilities for the mentally retarded under Part C of Title I of the Act. The Surgeon General shall adjust the allotments of such State upon either:

(1) Certification by the State agency that it has afforded from the date of availability of the first such allotment to the State a minimum of 18 months (but not exceeding the period of availability under the Act), and for any subsequent allotment to such State a minimum of 6 months, during which application could be made for the portion so specified and that no approvable applications for such funds were received during that period of time; or

(2) A demonstration satisfactory to the Surgeon General that the need for facilities for the mentally retarded is substantially greater than for community mental health centers, such demonstration to include the concurrence or other views of the State advisory council designated under section 204(a)(3) of Title II of the Act.

**§ 54.203 State plan; elements of adequate services; facilities; relationship to other planning.**

(a) *Adequate services.* The State plan shall provide for the following elements of service which are necessary to provide adequate mental health services for persons residing in the State, which shall constitute the elements of comprehensive mental health services:

(1) Inpatient services;

(2) Outpatient services;

(3) Partial hospitalization services, such as day care, night care, week-end care;

(4) Emergency services 24 hours per day must be available within at least one of the first three services listed above;

(5) Consultation and education services available to community agencies and professional personnel;

(6) Diagnostic services;

(7) Rehabilitative services, including vocational and educational programs;

(8) Precare and after-care services in the community, including foster home placement, home visiting and half-way houses;

(9) Training;

(10) Research and evaluation.

(b) *Adequate facilities*—(1) *Provision of services.* Based on comprehensive mental health planning, the State plan shall provide for adequate community mental health facilities for the provision of programs of comprehensive mental health services to all persons residing in the State and for furnishing such services to persons unable to pay therefor, taking into account the population necessary to maintain and operate efficient facilities and the financial resources available therefor.

(2) *Accessibility of services.* The State plan shall provide that every community mental health facility shall:

(i) Serve a population of not less than 75,000 and not more than 200,000 persons, except that the Surgeon General may, in particular cases, permit modifications of this population range if he finds that such modifications will not impair the effectiveness of the services to be provided;

(ii) Be so located as to be near and readily accessible to the community and population to be served, taking into account both political and geographical boundaries;

(iii) Provide a community service; and

(iv) Provide needed services for persons unable to pay therefor.

(c) *Financial feasibility.* The State plan shall set forth the policies and criteria to be used in evaluating the adequacy of financial support for the maintenance and operation of the program as described in § 54.212 when construction is completed, which shall include such factors as the proposed source or sources of funds, and the per capita and family income range of the population to be served.

(d) *Planning.* The State plan shall show that:

(1) It is consistent with the comprehensive mental health planning of the State;

(2) Cognizance has been taken of other health planning efforts and planning in such areas as urban development, welfare services and related facilities;

(3) In the case of interstate metropolitan areas, there has been consultation with the other State or States concerned; and

(4) To the maximum extent practicable, there has been coordination with city, metropolitan area and interstate planning agencies to achieve consistency between the State plan for, and the delineation of areas to be served by, community mental health facilities and other health, welfare, and physical development plans and activities.

**§ 54.204 State plan; areas; determination of relative need; priorities.**

(a) *Areas.* The State plan shall set forth a division of the State into geographical areas, and shall rank those areas according to their relative need for mental health services. Insofar as necessary data are available, the basic demographic and socioeconomic characteristics of the population within each area shall be described.

(b) *Relative need.* The relative need of areas shall be determined according to the information available concerning the following criteria, and the State plan shall indicate the relative weights assigned to each of these criteria in ranking the areas of the State.

(1) The extent of mental illness and emotional disorder, considering both the proportion of the population involved and the total number of people affected,

taking into account such related indices as:

(i) The existence of low per capita income, chronic unemployment, and substandard housing.

(ii) The extent of problems related to mental health, such as alcoholism and drug abuse, crime and delinquency.

(iii) The special needs of certain groups within the area, especially the physically and mentally handicapped, the aged and children.

(2) The present availability of public and private community mental health resources (including personnel and facilities), and the accessibility of those resources.

(c) *Priority of projects.* The State agency shall determine the relative priority of projects included in the State construction program in accordance with the relative need of the area to be served: *Provided*, That, if the community to be served by the proposed facility is smaller than the area in which it is located, then the relative need of communities within such area shall be determined in accordance with the criteria in paragraph (b) of this section, giving special consideration to:

(1) The extent to which the proposed project will, alone or in conjunction with other facilities owned or operated by the applicant or affiliated or associated with the applicant, provide comprehensive mental health services to the community;

(2) The extent to which the proposed facility is to be a part of or closely associated with a general hospital.

### § 54.205 State plan; methods of administration.

(a) *Personnel administration.* A system of personnel administration on a merit basis shall be established and maintained with respect to the personnel employed in the administration of the State plan. Such a system shall include provision for:

(1) Impartial administration of the merit system;

(2) Operation on the basis of published rules or regulations;

(3) Classification of all positions on the basis of duties and responsibilities and establishment of qualifications necessary for the satisfactory performance of such duties and responsibilities;

(4) Establishment of compensation schedules adjusted to the responsibility and difficulty of the work;

(5) Selection of permanent appointees on the basis of examinations so constructed as to provide a genuine test of qualifications and so conducted as to afford all qualified applicants opportunity to compete;

(6) Advancement on the basis of capacity and meritorious service; and

(7) Tenure of permanent employees.

Substantial compliance with the Standards for a Merit System of Personnel Administration, issued by the Secretary of Health, Education ,and Welfare, the Secretary of Labor, and the Secretary of Defense on January 26, 1963, 28 F.R. 734, including any subsequent amendments thereof, will be deemed to meet the requirements of the regulations in this part.

(b) *Conflict of interest.* No full-time officer or employee of the State agency, or any firm, organization, corporation, or partnership which such officer or employee owns, controls, or directs shall receive funds from the applicant directly or indirectly for payment for services provided in connection with the planning, design, construction or equipping of the project.

(c) *Publicizing the State plan.* At least thirty days prior to the submission of the State plan or any modification thereof to the Surgeon General, the State agency shall publish in newspapers having general circulation throughout the State, a general description of the proposed plan or any such modification, and the State plan shall be available for examination and comment by interested persons prior to submission to the Surgeon General.

(d) *Modification of the State plan.* The State agency shall from time to time as necessary, but not less often than annually, review the State plan, including the overall program for the construction of community mental health facilities, and shall submit to the Surgeon General any modifications of the plan and the construction program as the State agency considers necessary to administer the plan and the annual allotment.

(e) *Fair hearing.* The State agency shall establish such rules and regulations as will provide an opportunity for an appeal to and a fair hearing before the State agency to every applicant for a construction project who is dissatisfied with the action of the State agency regarding its application.

### § 54.206 State plan; processing of applications.

(a) *Submittal of applications.* Construction applications, including a detailed estimate of the cost of the project, shall be submitted to the Surgeon General through the State agency and shall be executed on forms prescribed by the Surgeon General.

(b) *Amendment to application.* An amendment to any application approved by the Surgeon General shall be processed in the same manner as an original application, except that the original application's conformity with the priority regulations shall suffice for an amendment which does not modify the factors on which the priority was granted.

(c) *Order of processing applications.* The State agency shall approve, recommend, and forward applications received in the order of priority, except that the State agency may approve, recommend, and forward to the Surgeon General applications out of the order of priority if:

(1) The State agency has afforded reasonable opportunity for development and presentation of projects in the order of priority, and

(2) The State agency certifies to the Surgeon General that financial resources for the construction, maintenance and operation of projects of higher priority are not then available.

The priority of a project under the State plan shall not be affected by the fact that other projects of lower priority have been approved and recommended by the State agency.

### § 54.207 State plan; construction program; design of facilities; minimum standards of operation and maintenance.

(a) *Standards of construction and equipment.* The State agency shall adopt general standards of construction and equipment for community mental health facilities which shall not be less than the general standards prescribed by the Surgeon General and set forth in the regulations in this part (§ 54.215, Appendix A—General standards of construction and equipment).

(b) *Development of construction program.* The State program for the construction of community mental health facilities shall be developed in the following manner:

(1) The State agency shall determine the need for facilities and services in accordance with the principles set forth in § 54.203 taking into account existing facilities and services.

(2) The State agency shall determine through field investigation and otherwise, the communities in or near which facilities should be constructed.

(3) After having determined the need for facilities and services, the State agency shall develop an overall construction program. The program shall set forth all such needs in accordance with the standards specified in § 54.203 and shall, insofar as funds are available provide for construction in the order of relative need determined in accordance with § 54.204.

(c) *Design of facilities.* The design of facilities for which Federal assistance is requested shall be based on an assessment of the requirements of the service to be provided in the facility and in any other facilities which may be part of the program containing the essential elements of comprehensive mental health services as defined in the regulations in this part. When the facility to be built under Title II of the Act is additive to a community program in which essential elements or other elements, or both, are already functioning, assessment of all the requirements of all these elements will be taken into consideration. The architectural plans submitted to the Surgeon General shall reflect such an assessment and shall also reflect the participation and concurrence of the agency or agencies responsible for the several elements of the program.

(d) *Submission of drawings.* The submission of drawings, construction outlines, and estimates for the approval of the Surgeon General shall be in the three stages required by the regulations in this part (Appendix A—General standards of construction and equipment). As soon as possible after the award of a construction contract, the applicant shall submit to the Surgeon General for approval, through the State agency, a complete list of all proposed equipment and an itemization of its estimated cost.

(e) *Minimum standards of maintenance and operation.* The State plan hall provide minimum standards for ie maintenance and operation of com-unity mental health facilities receiv-ig assistance under Title II of the Act.

**54.208 State plan; requests for construction payments; fiscal and accounting requirements.**

(a) *Certification by State agency.* he State agency shall certify to the urgeon General the amount of pay-ients due to an applicant for the cost f work performed and materials and quipment furnished.

(1) Except as provided in subpara-raph (2) of this paragraph, payments hall be made as follows:

(i) The first installment when not ss than 25 percent of the construction f the project has been completed;

(ii) A second installment when not ss than 50 percent of the construction f the project has been completed;

(iii) A third installment when not ss than 75 percent of the project has een completed;

(iv) A fourth installment when the roject is 95 percent completed; and

(v) The final payment when the proj-ct is completed and final inspection by representative of the Surgeon General made and the amount certified is due nd payable as determined by the audit.

(2) Upon a written request and a howing of necessity by the applicant, he Surgeon General may adopt a dif-rent schedule of payments.

(b) *Inspection by State agency.* As a asis for certification by the State agen-that payment of an installment is due n applicant, the State agency, without xpense to the Federal Government, shall ake adequate inspections to determine hat the work has been performed upon project, or purchases have been made, accordance with the approved plans nd specifications.

(c) *Fiscal and accounting requirements.* (1) Construction allotments.

(i) The State agency shall be respon-ible for establishing and maintaining ccounts and fiscal controls of all Fed-al and State funds allotted for con-ruction projects. Federal and State nds shall be separately identified by aintaining separate fund accounts for is purpose.

(ii) The fiscal records shall be so de-gned as to show at any given time the ederal funds allotted, encumbered, and nencumbered balances. If State con-ibutions are made for construction, parate accounts, reflecting similar in-rmation, shall be maintained for State nds.

(2) *Construction payments.* (i) here the State may receive Federal nds for applicants for construction oject grants, or the State itself is an pplicant, adequate records of account nd fiscal controls shall be established nd maintained by the State to assure oper accounting of all funds received nd disbursed. Similar suitable ac-unts shall be maintained to show the ceipt and disbursement of State, local, other funds used for matching urposes.

(ii) The State agency shall require that applicants receiving Federal funds established and maintain adequate accounting and fiscal records to reflect the receipt and expenditure of funds allotted and paid for construction projects.

(iii) The States which by law are authorized to make payments to applicants shall promptly pay such applicants funds certified for payment by the Secretary for approved construction projects.

**§ 54.209 State plan; assurances from applicant.**

In addition to any other requirements imposed by law each construction grant shall be subject to the condition that the applicant will furnish and comply with the following assurances. The Surgeon General may at any time approve exceptions to these assurances and conditions where he finds that such exceptions are not inconsistent with the Act and the purposes of the program.

(a) That applicant (or other public or nonprofit agency which is to operate the facility) has or will have a fee simple or such other estate or interest in the site, including necessary easements and rights-of-way, sufficient to assure for a period of not less than 50 years undisturbed use and possession for the purpose of the construction and operation of the facility.

(b) That the Surgeon General's approval of the final working drawings and specifications which conform to the general standards of construction and equipment will be obtained before the project is advertised or placed on the market for bidding.

(c) That the applicant will perform the actual construction work by the lump sum (fixed price) contract method; employ adequate methods of obtaining competitive bidding prior to awarding the construction contract either by public advertising or circularizing three or more bidders; and award the contract to the responsible bidder submitting the lowest acceptable bid: *Provided, however,* That the purchase and installation of equipment which is unique to the facility, as well as kitchen, laundry and laboratory equipment, need not be considered construction work for the purpose of this section except that if open competitive bidding is employed to obtain any or all of these items, the award shall be made to the responsible bidder submitting the lowest acceptable bid.

(d) That applicant will enter into no construction contract or contracts for the project or a part thereof, the cost of which is in excess of the estimated cost approved in the application for that portion of the work covered by the plans and specifications without the prior approval of the Surgeon General.

(e) That applicant will submit to the Surgeon General for prior approval changes that substantially alter the scope of work, function, utilities or safety of the facility.

(f) That applicant will construct the project, or cause it to be constructed, to final completion in accordance with the application and approved plans and specifications.

(g) That applicant will maintain adequate and separate accounting and fiscal records and accounts for all funds provided from any source to pay the cost of the project, and permit audit of such records and accounts at any reasonable time.

(h) That applicant will furnish progress reports and such other information as the Surgeon General may require.

(i) That applicant will provide and maintain competent and adequate architectural or engineering supervision and inspection at the construction site to insure that the completed work conforms with the approved plans and specifications.

(j) That sufficient funds will be available to meet the non-Federal share of the cost of constructing the facility.

(k) That sufficient funds will be available when construction is completed for effective use of the facility for the purpose for which it is being constructed.

(l) (1) That any laborer or mechanic employed by any contractor or subcontractor in the performance of work on the construction of the facility will be paid wages or rates not less than those prevailing on similar construction in the locality as determined under the Davis-Bacon Act (40 U.S.C. 276 et seq.) and will receive compensation at a rate not less than one and one-half times his basic rate of pay for all hours worked in any work week in excess of eight hours in any calendar day or forty hours in the work week (40 U.S.C. 327–332); and

(2) That the following conditions and provisions will be included in all construction contracts:

(i) The provisions of "Public Health Service Labor Standards for Construction Grant Programs" (PHS 930–A–5) pertaining to the Copeland Act (Anti-kickback) Regulations and Labor Standards (prevailing rates of pay and overtime requirements) except in the case of contracts in the amount of $2,000 or less;

(ii) The contractor shall furnish performance and payment bonds, each of which shall be in the full amount of the contract price, and shall maintain, during the life of the contract, adequate fire, workman's compensation, public liability and property damage insurance;

(iii) Representatives of the Surgeon General and State agency will have access at all reasonable times to work whenever it is in preparation or progress, and the contractor shall provide proper facilities for such access and inspection.

(m) That the facility will be operated and maintained in accordance with minimum standards prescribed by the State agency for the maintenance and operation of such facilities.

(n) That the services to be provided by the facility, alone or in conjunction with other facilities owned or operated by the applicant, will be made available for a program providing, principally for persons residing in a particular community or communities in or near which such facility is to be situated, at least those essential elements of comprehensive mental health services prescribed in § 54.212.

(o) That the applicant will conform to all the applicable requirements of the State plan and the regulations in this part.

**§ 54.210 State plan; community service; nondiscrimination; services for persons unable to pay.**

Before a construction application for a community mental health facility is recommended by a State agency or approval, the State agency shall obtain assurance from the applicant that:

(a) The facility will furnish a community service;

(b) All portions and services of the entire facility for the construction of which, or in connection with which, aid under the Act is sought, will be made available without discrimination on account of race, creed, or color; and that no professionally qualified person will be discriminated against on account of race, creed, or color with respect to the privilege of professional practice in the facility;

(c) That the facility will furnish below cost or without charge a reasonable volume of services to persons unable to pay therefor. As used in this paragraph, "persons unable to pay therefor" includes both the legally indigent and persons who are otherwise self-supporting but are unable to pay the full cost of needed services. Such services may be paid for wholly or partly out of public funds or contributions of individuals and private and charitable organizations such as Community Chest or may be contributed at the expense of the community mental health facility itself. In determining what constitutes a reasonable volume of services, there shall be considered conditions in the area to be served by the applicant, including the amount of such services that may be available otherwise than through the applicant. The requirement of assurance from the applicant may be waived if the applicant demonstrates to the satisfaction of the State agency, subject to subsequent approval by the Surgeon General, that to furnish such services is not feasible financially.

**§ 54.211 State plan; approval and certification of application.**

After the State agency has approved a construction application, it shall recommend it to the Surgeon General for approval and shall certify:

(a) That the application contains reasonable assurance as to the availability of funds for the cost of construction and the entire cost of maintenance and operation when completed.

(1) Availability of funds for the non-Federal share of construction costs shall mean:

(i) Funds immediately available, placed in escrow, or acceptably pledged, or

(ii) Funds or fund sources specifically earmarked in a sum sufficient for that purpose, or

(iii) Other assurances acceptable to the Surgeon General.

(2) To assure the availability of funds for maintenance and operation, the application for the construction of a new project must include a proposed operating budget for the two-year period immediately following its completion. In the case of an addition to an existing facility, the application must include a statement showing that funds are or will be available to meet the difference between proposed expenditures and anticipated income from the operation of the constructed addition for the two-year period immediately following its completion.

(b) That the application is in conformity with and contains the assurances required by the State plan and the regulations in this part.

(c) That the application contains reasonable assurance of the financial feasibility of the program of comprehensive mental health services which the project will provide or of which it is to be a part.

**§ 54.212 Projects; essential elements of comprehensive mental health services; program requirements.**

(a) *Essential elements of comprehensive mental health services.* The essential elements of comprehensive mental health services are:

(1) Inpatient services.

(2) Outpatient services.

(3) Partial hospitalization services—must include at least day care service.

(4) Emergency services provided 24 hours per day must be available within at least one of the first three services listed above.

(5) Consultation and education services available to community agencies and professional personnel.

(b) *Services of facility as part of a program.* To the extent that the services to be provided within the proposed facility do not constitute a program providing at least the essential elements of comprehensive mental health services, the application shall demonstrate to the satisfaction of the Surgeon General that the services to be provided within the proposed facility will be part of such a program (as described below).

(c) *Criteria of program.* As used in this section, a program for providing at least the essential elements of comprehensive mental health services must take into consideration the needs of all age groups, assure continuity of care for patients and assure that the relationship between the individual elements of the services meets the following criteria:

(1) (i) That any person eligible for treatment within any one element of service will also be eligible for treatment within any other element of service;

(ii) That any patient within any one element can and will be transferred without delay to any other element (provided that adequate space is available) whenever such a transfer is indicated by the patient's clinical needs;

(iii) The clinical information concerning a patient which was obtained within one element be made available to those responsible for that patient's treatment within any other element;

(iv) That those responsible for a patient's care within one element can, when practicable and when not clinically contraindicated, continue to care for that patient within any of the other elements; and

(v) In cases where two or more of the individual elements of services are provided by different organizations, agencies, or persons, the relationships between the individual elements must be evidenced by appropriate contracts or other formal written agreements (copies of which must accompany the application) among the various organizations, agencies, or persons which make specific provisions for assuring compliance with the criteria set forth in this section.

(2) That a qualified psychiatrist will be responsible for the clinical program and the medical responsibility for every patient will be vested in a physician.

(3) That general practitioners and other non-psychiatric physicians in the community served by the program will be allowed, when qualified, to follow and assist in the care of their patients on the various services of the program provided they are working under the supervision of a member of the psychiatric staff of the service.

(4) That the services of the program will not be denied to any person residing within the area served solely on the ground that such person does not meet a requirement for a minimum period of residence in such area.

(d) *Budgetary and staffing pattern.* The application shall include a description of the proposed sources of operating income for all elements of service included in the program and a proposed operating program budget for the two year period immediately following the completion of construction of the facility. There shall also be included the proposed staffing pattern for all elements of the program by major professional categories.

**§ 54.213 Change of status of facility.**

The State agency shall promptly notify the Surgeon General in writing, if at any time within 20 years after the completion of construction, any facility which received funds under Title II of the Act is sold or transferred to any person, agency, or organization not qualified to file an application under Title II of the Act or is not approved as a transferee by the State agency, or ceases to be a public or nonprofit community mental health center as defined in the Act.

**§ 54.214 Good cause for other use of facility.**

If within 20 years after completion of any construction for which a construction grant has been made the facility shall cease to be a public or nonprofit community mental health center, the Surgeon General in determining whether there is good cause for releasing the applicant or other owner of the facility from the obligation to continue such facility as a public or other nonprofit community mental health center, shall take into consideration the extent to which

(a) The facility will be devoted by the applicant or other owner to use for another public purpose which will promote the purpose of the Act; or

(b) There are reasonable assurance that for the remainder of the 20 year period other facilities not previously utilized for the care of the mentally ill will be so utilized and are substantially equivalent in nature and extent for such purposes.

§ 4.215 Appendix A—General standards of construction and equipment.

(a) *Introduction.* Th in this section have been estab- ished by the Secretary as required by t Act. These standards constitute n imum requirements for construction a l equipment, and shall apply to all p jects for which Federal assistance is r uested under the Act. The Surgeon C eral may approve plans and specifi- c ions which contain deviations from t requirements prescribed, if he is sat- s d that the purposes of such require- m nts have been fulfilled. In addition to t se requirements, it is recognized that t project will have to meet the require- m nts of local codes and ordinances re- l ng to construction.

(b) *Flexibility.* All project facilities s ll be designed and constructed so as t permit maximum flexibility in the pro- p ed uses of those facilities. Provision s ll be made, wherever possible, for fu- t e expansion of the floor areas and the r cation of interior partitions.

(c) *Architectural.* (1) Facilities shall b fire safe, structurally safe, and so p nned as to carry out effectively the p posed program. The following re- q rements have been established to as- s e an orderly development of the proj- e and to provide a uniform method for t preparation and review of drawings, s cifications, and estimates.

(2) The submission of drawings, con- s uction outlines, and estimates shall be i three stages as follows: (Such mate- r is in addition to program and finan- c information in connection with such a plications as may be required by the S geon General).

(i) *First stage.*

Schematic plans.[1]
Outline specifications.
Site survey.
Estimated construction costs.

(ii) *Second stage.*

Preliminary plans.
Outline specifications.
Revised cost estimates.

(iii) *Third stage.*

Working drawings.
Specifications.
Final cost estimates.

(d) *Construction.* (1) One-story buildings shall be constructed of noncombustible materials of not less than one-hour fire-resistive construction throughout except as follows:

(i) Boiler rooms and rooms used for the storage of combustible materials shall be of two-hour fire-resistive noncombustible construction.

(ii) Interior nonload-bearing partitions, other than those enclosing corridors and vertical shafts, may be of noncombustible construction without a fire-resistive rating.

(2) Buildings more than one story in height shall be constructed of noncombustible materials, using a structural framework of reinforced concrete or structural steel except that load-bearing masonry walls and piers may be utilized for buildings up to and including three stories in height. The fire-resistive requirements of the various building elements shall be of not less than the following hourly ratings:

| | *Hours* |
|---|---|
| Columns, girders, trusses | 1½ |
| Floor construction including beams | 1½ |
| Roof construction including beams | 1 |
| Beams supporting masonry; individually protected | 2 |
| Bearing walls | 2 |
| Corridor partitions | 1 |
| Walls enclosing stairways, elevator shafts, chutes and other vertical shafts, boiler rooms and rooms used for storage of combustible materials | 2 |

(3) Subject to prior approval by the Surgeon General, these requirements may be varied for free-standing facilities containing only outpatient, educational, recreational, or workshop functions utilized by ambulant groups.

(4) Interior finish walls and ceilings of all exitways, storage rooms, laboratories, and areas of unusual fire hazard shall have a flamespread rating of less than 20. Flamespread ratings shall be on the basis of tests conducted in accordance with American Society for Testing Materials, Publication No. E84.

(5) Exit facilities shall comply with the requirements of the Building Exits Code, National Fire Protection Association Bulletin No. 101.

(e) *Mechanical.* All installations of fuel burning equipment, steam, heating, air conditioning and ventilation, and plumbing systems shall comply with the requirements of the following National Codes:

(1) National Board of Fire Underwriter Standards: National Board of Fire Underwriters, 85 John St., New York 38, N.Y.

(2) National Fire Protection Association: 60 Batterymarch St., Boston 10, Mass.

(3) American Standards Association: 70 East 45th St., New York 17, N.Y.

(4) American Gas Association: 1725 I St., Washington, D.C.

(5) National Plumbing Code: Published by American Society of Mechanical Engineers, 29 West 39th St., New York 18, N.Y.

Boilers shall meet the requirements of the American Society of Mechanical Engineers (A.S.M.E. Codes relating to pressure vessels), and shall be installed to meet the requirements of State and local codes and regulations.

(f) *Electrical.* All electrical installations and equipment shall comply with the requirements of local and State codes and the applicable sections of the National Electrical Code and the following:

(1) *Hazardous locations.* Installations and equipment in rooms in which flammable anesthetic and disinfecting agents are used or stored shall comply with the requirements of NFPA No. 56 and No. 70.

(2) *Fire alarms.* Manually operated fire alarm system installations shall comply with the requirements of NFPA No. 72 and shall be located as required by the Building Exits Code, NFPA No. 101.

(3) Radiation protection in rooms in which X-ray, gamma-ray, or beta-ray producing equipment is used shall comply with the requirements of the following handbooks of the National Bureau of Standards:

Handbook 55, Protection Against Betatron-Synchrotron Radiations up to 100 Million Electron Volts.
Handbook 73, Protection Against Radiations From Sealed Gamma Sources.
Handbook 76, Medical X-ray Protection up to Three Million Volts.

(4) *Emergency electric service.* Emergency exit lighting shall comply with the requirements of the National Electrical Code and shall be located as required by the Building Exits Code.

(g) *Elevators, dumbwaiters, and escalators.* Installation of elevators, dumbwaiters, and escalators shall comply with the requirements of the American Standard Safety Code for Elevators, Dumbwaiters, and Escalators, ASA A17.1–1960.

(h) Equipment necessary for the functioning of the facility or the program as planned shall be provided in the kind and to the extent required to perform the desired service. The necessary equipment may be included in the cost of the project.

[1] Schematic drawings are considered an integral part of the program description to be provided in the initial application.

# APPENDIX C

## MONTANA LEGISLATION PROPOSED AND PASSED 1965 SIGNIFICANT TO MENTAL HEALTH

HOUSE SUBSTITUTE FOR HOUSE BILL NO. 19

A BILL FOR AN ACT ENTITLED:

AN ACT TO PROVIDE FOR MEDICAL ASSISTANCE FOR THE AGED IN CONFORMITY WITH TITLE I OF THE FEDERAL SOCIAL SECURITY ACT OF 1935, AS AMENDED; PROVIDING FOR THE ADMINISTRATION OF THE ACT BY THE STATE DEPARTMENT OF PUBLIC WELFARE AND THE COUNTY DEPARTMENTS OF PUBLIC WELFARE; PROVIDING ELIGIBILITY REQUIREMENTS FOR ASSISTANCE UNDER THE ACT; PROVIDING FOR COUNTIES' SHARE OF PARTICIPATION UNDER THE ACT; AND AMENDING SECTIONS 71-106, 71-211, 71-230, 71-241, 71-308, 71-309, 71-402, 71-405 AND 71-406, R.C.M., 1947 TO PROVIDE VENDOR PAYMENT OF MEDICAL CARE FOR RECIPIENTS OF OLD AGE ASSISTANCE.

* * * * * *

HOUSE BILL NO. 62

INTRODUCED BY WATT, HAINES AND TRACY

A BILL FOR AN ACT ENTITLED: "AN ACT TO APPROPRIATE MONEY TO THE SUPERINTENDENT OF PUBLIC INSTRUCTION FOR THE BIENNIUM ENDING JUNE 30, 1967; PROVIDING THAT THIS APPROPRIATION SHALL BE USED TO PROVIDE PSYCHOLOGICAL TESTING SERVICES ONLY, PURSUANT TO TITLE 75, CHAPTERS 14 AND 50, REVISED CODES OF MONTANA, 1947."

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF MONTANA:

Section 1. Sixty three thousand dollars ($63,000.00) is hereby appropriated from the general fund for the biennium ending June 30, 1967 to the superintendent of public instruction. This appropriation shall be used to provide psychological testing services in the public schools of this state, pursuant to the provisions of Title 75, Chapters 14 and 50, R.C.M., 1947, only.

Section 2. This appropriation may be expended for the employment of qualified public school psychologists and for all ordinary and necessary expenditures incurred in the operation of the special educational program authorized by Title 75, Chapters 14 and 50, R.C.M., 1947.

HOUSE BILL NO. 102

INTRODUCED BY SCHEPENS, CUMMINGS, McDONALD, BOLLINGER, MECCAGE, STRANAHAN, HARPER, O'HAIR, SARTZ, PREVOST, EKLUND, AASHEIM, GERKE, O'LEARY, FLYNN, HANKS, GUNDERSON, TWEDT, NEFZGER, DESCHAMPS

A BILL FOR AN ACT ENTITLED: "AN ACT TO PROVIDE A COMPREHENSIVE FACILITY FOR DIAGNOSIS, EVALUATION, TREATMENT, REHABILITATION, PROFESSIONAL IN-SERVICE TRAINING, COMMUNITY CONSULTATIVE AND PREVENTIVE SERVICES AND RESEARCH IN THE FIELDS OF MENTAL HEALTH, MENTAL RETARDATION, GUIDANCE AND JUVENILE REHABILITATION IN MONTANA; CREATING AN ADVISORY COUNCIL; AND APPROPRIATING $1,800,000 TO THE DEPARTMENT OF PUBLIC INSTITUTIONS FOR PURCHASE OF SITE AND THE CONSTRUCTION AND EQUIPPING OF SUCH FACILITY."

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF MONTANA:

Section 1. The Department of Public Institutions is authorized:

(1) to establish a multi-purpose, comprehensive facility for diagnosis, evaluation, treatment, guidance, juvenile rehabilitation, community consultative and preventive services for mentally retarded, mentally ill or other socially handicapped persons who may be referred to or otherwise admitted to said facility.

(2) by provision of said facility and additional services, to extend and strengthen Montana services in these fields.

The Department of Public Institutions shall also provide at said facility opportunities for research, including statistical reporting and continuing evaluation of Montana needs, and for professional personnel in-service training that will enhance Montana's potential for attracting, training and retaining qualified professional personnel, in the aforementioned fields of service.

Section 2. For purposes of this act, comprehensive facility shall mean that building or complex of buildings to be erected, equipped and professionally staffed to provide, and effect needed coordination of, the afore-mentioned services in the fields of mental health, mental retardation, guidance and juvenile rehabilitation.

Section 3. To guarantee provision of said multiple services to persons in all of the several fields named eligible for services under this act, the Director of Public Institutions shall serve as Chairman of an Advisory Council to the Board of Public Institutions, the Executive Officer of the State Board of Health, the State Superintendent of Public Instruction, the Director of the Division of Vocational Rehabilitation, the Administrator of the Department of Public Welfare and the Chairman of the Unemployment Compensation Commission, or their designated representatives, together with representatives of other state agencies and private and/or voluntary organizations as the State Board of Public Institutions may from time to time appoint.

Section 4. The sum of $1,800,000 is herewith appropriated to the Department of Public Institutions for the pruchase of site, and the construction and equipping of a comprehensive facility at a location to be determined by the Board of Public Institutions after consultation with the Montana Mental Health Planning Committee and the Montana Mental Retardation Planning Committee with regard to said Committees' findings on unmet state-wide needs in mental health and mental retardation.

Section 5. Should funds be available on a matching basis from any federal, or any public or private agency, which funds could be used for the purpose specified in this act, nothing herein shall be construed as

preventing the use of any or all of the state funds hereby appropriated to obtain such matching funds. Provided, however, that all funds hereby appropriated and all funds obtained by such matching procedure shall be used for the purpose of this act and for no other purpose.

HOUSE BILL NO. 282

INTRODUCED BY BOLLINGER, BAILEY, AASHEIM, NEFZGER, CASEY AND LUND

A BILL FOR AN ACT ENTITLED: "AN ACT TO APPROPRIATE MONEY FOR THE INSTITUTION OF A MENTAL HYGIENE CLINIC IN THE CITY OF GLASGOW, MONTANA FOR THE PEOPLE RESIDING IN NORTH EASTERN MONTANA TO BE ESTABLISHED AND OPERATED BY THE STATE DEPARTMENT OF MENTAL HYGIENE AND PROVIDING AN EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF MONTANA:

Section 1. It is the purpose of this act to aid in the protection of the health and safety of the people of Montana and for that purpose to provide a mental health clinic for the north east portion of this state which is a vast area with a substantial number of citizens who otherwise are required to travel great distances to reach the mental hygiene clinics presently established and existing in this state.

Section 2. There is appropriated from the general fund eighty thousand dollars ($80,000) for the establishment and operation of a mental health clinic in Glasgow, Montana, by the state department of mental hygiene, to be established and operated under the provisions of section 38-1003, R.C.M. 1947, for the biennium beginning July 1, 1965.

Section 3. This act is effective on its passage and approval.

HOUSE BILL NO. 535

AN ACT APPROPRIATING MONEYS TO THE DEPARTMENT OF PUBLIC INSTITUTIONS AND THE BOARD OF EDUCATION FOR CAPITAL PROJECTS.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF MONTANA:

Section 1. Three million six hundred thirty-nine thousand eight hundred seventeen dollars ($3,639,817) is appropriated to the department of institutions and board of education from the long range building program account in the bond proceeds and insurance clearance fund for the biennium ending June 30, 1967, for the following capital projects. The cost of each project shall not exceed the amount indicated for the project.

TO THE BOARD OF EDUCATION
FOR THE SCHOOL FOR THE DEAF AND BLIND

| | | |
|---|---|---|
| 1. | Classroom building addition, expansion of existing facilities | $158,067 |
| 2. | Sprinkler system for main building, recommended by state fire marshal | $ 25,000 |
| 3. | Fire hydrant and line, recommended by state fire marshal | $ 3,000 |
| 4. | Maintenance items excluded from operating budget | $ 8,500 |

TO THE DEPARTMENT OF INSTITUTIONS
TUBERCULOSIS SANITARIUM

| | | |
|---|---|---|
| 1. | Repair roofs | $ 11,000 |
| 2. | Repair steam lines | $ 21,000 |

SOLDIERS' HOME

| | | |
|---|---|---|
| 1. | Repair, renovate, equip hall for members and renovate kitchen - dining room and equipment | $ 30,000 |

STATE PRISON

| | | |
|---|---|---|
| 1. | Expand water system and equip | $ 45,000 |
| 2. | Repair and replace lock-system in two hundred cell blocks | $ 30,550 |
| 3. | New butcher shop | $ 30,000 |
| 4. | New women's facility for female prisoners | $ 25,000 |
| 5. | New X-ray machine | $ 10,000 |

INDUSTRIAL SCHOOL

| | | |
|---|---|---|
| 1. | Repair water lines and add steam tunnels | $ 60,000 |
| 2. | Demolition of old gym | $ 2,000 |
| 3. | Renovate and equip kitchen | $ 80,000 |
| 4. | Renovate and equip infirmary | $ 8,000 |
| 5. | Renovate and equip laundry | $ 25,000 |
| 6. | Repair electric and plumbing shop | $ 5,000 |
| 7. | Renovate butcher shop | $ 4,000 |
| 8. | New school and vocational rehabilitation building or cottages | $375,000 |

CHILDREN'S CENTER

| | | |
|---|---|---|
| 1. | New boiler | $ 55,000 |
| 2. | Repair, renovate, reroof cottages and gymnasium and provide new water supply system | $130,000 |
| 3. | Repair water tank | $ 7,000 |

STATE HOSPITAL

| | | |
|---|---|---|
| 1. | Renovation of heating system | $198,000 |
| 2. | Pipe line repairs and maintenance | $ 14,000 |
| 3. | Fire escapes | $ 9,600 |
| 4. | Multipurpose building for patients | $350,000 |

TRAINING SCHOOL AND HOSPITAL

| | | |
|---|---|---|
| 1. | Reroof junior hall | $ 35,000 |
| 2. | Renovate and refrigerate butcher shop | $ 8,500 |
| 3. | Insulate existing steam line | $ 1,000 |
| 4. | Floors and insulation in attics | $ 3,500 |
| 5. | Guards and grilles for windows and radiators | $ 2,500 |
| 6. | Screen doors and windows | $ 2,500 |
| 7. | One thousand foot underground high voltage system | $ 4,000 |
| 8. | Transformer and electrical lines | $ 3,500 |
| 9. | Hospital ventilating equipment | $ 2,000 |
| 10. | Hospital fire door | $ 400 |
| 11. | Nine fire escapes<br>Cottage 1 - 1<br>Cottage 2 - 2<br>Cottage 4 - 2<br>Cottage 5 - 2<br>Boys' hall - 2 | $ 13,500 |
| 12. | Lay nonconductive tile on floor of hospital operating room | $ 1,000 |
| 13. | Complete the renovation and kitchen equipment for Griffin Hall | $ 20,000 |

HOME FOR THE SENILE AGED

| | | |
|---|---|---|
| 1. | Repair heating system | $ 2,600 |
| 2. | Fire alarm hook-up | $ 1,550 |

VOCATIONAL SCHOOL FOR GIRLS

| | | |
|---|---|---|
| 1. | Renovation and consolidation of kitchens and equipment | $ 90,000 |
| 2. | Water well and pump | $ 3,000 |
| 3. | Repair, renovate, rewire, reroof three cottages, gymnasium and school building and equip | $ 60,000 |

| | |
|---|---|
| 4. Drain swamp from campus | $ 8,000 |
| 5. Master key system | $ 4,550 |
| 6. Laundry | $ 9,000 |

DEPARTMENT OF INSTITUTIONS

| | |
|---|---|
| 1.. Youth forest camp for boys | $ 324,000 |
| 2. Diagnostic and treatment center | $2,180,000 |

Section 2. With the consent of the department of institutions, moneys allocated for a project may be used for any other project at the same institution. With the consent of the governor, on the request of the department of institutions, moneys allocated for a facility may be used for any other facility at any other institution.

Section 3. There is also appropriated to the department of institutions all moneys from federal, or private or other sources which may be available to finance the capital projects included in this act.

Section 4. There is hereby created an interim committee on state buildings consisting of four members of the senate appointed by the senate committee on committees and four members of the house of representatives appointed by the speaker. No more than two members of each house shall be appointed from the same political party. Such committee shall review all building projects provided for by this 39th legislative assembly.

The eight member committee shall appoint a qualified building engineer to serve at the pleasure of the committee at a salary set by the committee. The committee shall furnish transportation and per diem for said employee. The building engineer shall keep accurate records of all

buildings under construction, review proposed construction and repair plans and make monthly reports to each member of the committee. The said committee shall meet quarterly and at such other times as construction progress requires. The Legislative Council staff shall cooperate in carrying out the provisions of this act.

Section 5. Forty-seven thousand five hundred dollars ($47,500) is appropriated from the long range building program account in the bond proceeds and insurance clearance fund to the committee on state buildings for operation for the biennium ending June 30, 1967.

CHAPTER NO. 199
MONTANA SESSION LAWS 1965
SENATE BILL NO. 7

AN ACT FOR THE CODIFICATION AND GENERAL REVISION OF THE LAWS RELATING TO THE DEPARTMENT OF INSTITUTIONS AND THE FOLLOWING INSTITUTIONS; MONTANA VETERANS' HOME, STATE HOSPITAL, STATE PRISON, STATE PULMONARY DISEASE HOSPITAL, MONTANA CENTER FOR THE AGED, STATE INDUSTRIAL SCHOOL, STATE TRAINING SCHOOL AND HOSPITAL, MONTANA CHILDREN'S CENTER AND STATE VOCATIONAL SCHOOL FOR GIRLS; AMENDING SECTIONS,

* * *

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF THE STATE OF MONTANA:

* * * * * *

DIVISION OF MENTAL HYGIENE -- STATE HOSPITAL

Section 67. The institution located at Warm Springs is the "State Hospital". The only function of the state hospital is the care and treatment of mentally ill persons and alcoholics. The state hospital is in the division of mental hygiene of the department of institutions.

Section 68. The superintendent of the state hospital is the supervisor of the division of mental hygiene. The superintendent shall be a licensed physician who has fulfilled the residency requirements of the American Board of Psychiatry and Neurology in the speciality of psychiatry.

Section 69. The division of mental hygiene of the department of institutions shall:

(1) Take cognizance of matters affecting the mental health of the citizens of the state.

(2) Initiate preventive mental hygiene activities of the state's mental health program.

(3) Make scientific and medical investigations relative to the incidence, cause, prevention and care of mental illness.

(4) Collect and disseminate information relating to mental hygiene.

(5) Prepare plans for the development of mental health services in the state.

(6) Examine persons received into the state hospital and other persons who apply for examination, for the purpose of diagnosing and prescribing treatment of mental illness.

(7) Establish and conduct clinics in cities and towns of the state for the diagnosis and treatment of mental illness.

(8) Receive from agencies of the United States and other agencies grants of money for the development of mental hygiene services within the state, and use such moneys in its operation.

Section 70.

(1) There is an alcoholism services center at the state hospital. The admittance and discharge procedures for alcoholics are the same as for mentally ill persons.

(2) As used in this section:

(a) "Alcoholism" means a chronic illness or disorder of behavior characterized by repeated drinking of alcoholic beverages to an extent which endangers the drinker's health, interpersonal relations or economic functioning, or to an extent which endangers the public health, welfare or safety.

(b) An "Alcoholic" is a person suffering from the illness of alcoholism.

(3) The alcoholism services center shall:

(a) Provide custody, care, diagnosis, treatment and rehabilitation to persons in Montana who seek, or are required to seek, relief from the illness of alcoholism or the complications thereof;

(b) Consult with, inform, guide and cooperate with Montana communities and citizens' committees who seek assistance in establishing local alcoholism treatment, rehabilitation and public information services;

(c) Accumulate and disseminate scientific information on alcoholism to all agencies, groups and individuals, public or private, who require or seek such services;

(d) Initiate, encourage and coordinate practical research on alcoholism in Montana aimed at improving treatment, rehabilitation and prevention techniques or services; and

(e) Enter into cooperative agreement with other state agencies to further the work of the center.

* * * * * *

SENATE BILL NO. 57

AN ACT AMENDING SECTIONS 69-3001, 69-3003, 69-3004, 69-3007, 69-3008, 69-3009, 69-3010, 69-3012, 69-3013, 69-3014, AND 69-3015, AS AMENDED, R.C.M. 1947, RELATING TO HOSPITAL SURVEY AND CONSTRUCTION; PROVIDING FOR THE DEVELOPMENT AND ADMINISTRATION OF HOSPITAL, MEDICAL AND RELATED FACILITY CONSTRUCTION AND ALTERATION PROGRAMS; PROVIDING FOR COMPLIANCE WITH REQUIREMENTS OF FEDERAL ACTS AND REGULATIONS TO SECURE ASSISTANCE IN SUCH PROGRAMS; DESIGNATING AND AUTHORIZING THE STATE BOARD OF HEALTH AS THE AGENCY OF THE STATE OF MONTANA FOR THE DEVELOPMENT AND ADMINISTRATION OF SUCH PROGRAMS AND EMPOWERED TO CONTRACT WITH THE FEDERAL GOVERNMENT IN FURTHERANCE THEREOF; REPEALING SECTION 69-3006, R.C.M. 1947; AND PROVIDING AN EFFECTIVE DATE.

* * * * * *

SENATE BILL NO. 58

AN ACT AMENDING SECTIONS 69-2901, 69-2902, 69-2903, 69-2905, 69-2906, 69-2907, 69-2908, 69-2910, 69-2911, 69-2915, 69-2916 AND 69-2917, R.C.M. 1947, RELATING TO HOSPITAL LICENSING AND SUPERVISION BY THE STATE BOARD OF HEALTH TO INCLUDE LICENSING AND SUPERVISION OF MEDICAL FACILITIES AND FACILITIES FOR MENTAL DISEASES AND MENTAL RETARDATION; ALTERING THE COMPOSITION, POWERS AND TITLE OF THE ADVISORY HOSPITAL COUNCIL WITH REGARD TO SUCH LICENSING AND SUPERVISION; REPEALING SECTION 69-2910.1, R.C.M. 1947; AND PROVIDING AN EFFECTIVE DATE.

* * * * * *

CHAPTER NO. 247
MONTANA SESSION LAWS 1965
SENATE BILL NO. 111

AN ACT RELATING TO THE LICENSING OF DAY CARE FACILITIES FOR CHILDREN.

* * * * * *

# APPENDIX D

# SUPPORTIVE DATA

Local Affiliates of Montana Committee on Alcoholism

1. Western Montana Committee on Alcoholism - Missoula, Montana
2. Northwestern Montana Committee on Alcoholism - Kalispell, Montana
3. North Central Montana Committee on Alcoholism - Great Falls, Montana
4. Central Montana Committee on Alcoholism - Lewistown, Montana
5. Richland County Committee on Alcoholism - Billings, Montana
6. Midland Empire Committee on Alcoholism - Billings, Montana
7. Park County Committee on Alcoholism - Livingston, Montana
8. Gallatin County Committee on Alcoholism - Bozeman, Montana
9. Silver Bow County Committee on Alcoholism - Butte, Montana
10. Deer Lodge County Committee on Alcoholism - Anaconda, Montana

# APPENDIX E

# PROJECT ORGANIZATION DATA

## MONTANA STATE MENTAL HEALTH AUTHORITY

Stanley J. Rogers, M.D.
Superintendent - Montana State Hospital
Supervisor - Division of Mental Hygiene

## PLANNING COMMITTEE

CHAIRMAN OF PLANNING AND STEERING COMMITTEES
*The Reverend John S. W. Fargher, D.D.
15 North Idaho
Butte, Montana
Representing - Montana Association for Mental Health
Occupation - Minister

VICE-CHAIRMAN OF PLANNING AND STEERING COMMITTEES
*Joseph Roe
State Department of Public Welfare
P.O. Box 1723
Helena, Montana
Representing - State Department of Public Welfare
Occupation - Social Worker

*Mrs. George Allen
P.O. Box 436
Livingston, Montana
Representing - Governor's Joint Committee on Mental Health and Mental Retardation
Occupation - Graduate Student

G. Clark Anderson, ACSW
1130 17th Avenue South
Great Falls, Montana
Representing - National Association of Social Workers
Occupation - Social Worker

*John S. Anderson, M.D.
State Board of Health
Helena, Montana
Representing - State Board of Health
Occupation - Public Health Doctor

Walter Anderson
State Department of Administration
State Capitol Building
Helena, Montana
Representing - State Department of Administration
Occupation - Accountant

*Glenn Bailey
Montana Deaconess Hospital
Great Falls, Montana
Representing - Montana Hospital Association
Occupation - Hospital Administrator

Anna T. Beckwith
Montana Nursing Board
Sam Mitchell Building
Helena, Montana
Representing - Montana Nursing Board
Occupation - Registered Nurse

**Pastor Clifford A. Brooks
120 East Sixth
Anaconda, Montana
Representing - Chairman, District No. 9
Occupation - Minister

Alma L. Carlisle
Montana State Training School and Hospital
Boulder, Montana
Representing - Montana State Training School and Hospital
Occupation - Psychologist

Paul Carpino
Montana State Prison
Deer Lodge, Montana
Representing - Montana State Prison
Occupation - Director-Social Service

Thomas Connors
State Department of Public Welfare
P.O. Box 1723
Helena, Montana
Representing - State Department of Public Welfare
Occupation - Accountant

Mrs. Frances W. Dixon, ACSW
Public Health Service
P.O. Box 2143
Billings, Montana
Representing - Division of Indian Health
Occupation - Social Worker

**Mrs. Florence Dolighan
Gallatin County Department of Public Welfare
Bozeman, Montana
Representing - Gallatin County Department of Public Welfare
Occupation - Social Worker

A. G. Erickson
1232 East Sixth Avenue
Helena, Montana
Representing - Montana Education Association
Occupation - School Administrator

**The Reverend Helmuth Fichtler
633 Sixth Avenue North
Glasgow, Montana
Representing - Chairman, District No. 4
Occupation - Minister

**Mrs. Maurice Fladstol
Conrad, Montana
Representing - Chairman, District No. 2
Occupation - Housewife

Mrs. Louis Forsell
P.O. Box 449
Helena, Montana
Representing - Montana Health Planning Council
Occupation - Housewife

Bernard F. Grainey
Veterans Administration
Fort Harrison, Montana
Representing - Montana Bar Association
Occupation - Attorney

**Mrs. Louis Hagener
612 17th Street
Havre, Montana
Representing - Chairman, District No. 3
Occupation - Housewife

Maurice Harmon, ACSW
Department of Public Institutions
Sam Mitchell Building
Helena, Montana
Representing - State Department of Public Institutions
Occupation - Social Worker

**Mrs. Hugh Herbert
626 Eddy Avenue
Missoula, Montana
Representing - Chairman, District No. 10
Occupation - Housewife

Gladys Holmes, M.D.
Mental Hygiene Clinic
University Health Center
Missoula, Montana
Representing - Montana Congress of Parents and Teachers
Occupation - Psychiatrist

**A. W. Hook
Anaconda Aluminum Plant
Columbia Falls, Montana
Representing - Chairman, District No. 1
Occupation - Chemist

Grant K. Hyer, ACSW
Veterans Administration
Fort Harrison, Montana
Representing - Veterans Administration
Occupation - Social Worker

**William Ikard
Dawson County Department of Public Welfare
Glendive, Montana
Representing - Chairman, District No. 5
Occupation - Social Worker

Ralph A. Jackson
Montana State Employment Service
P.O. Box 1728
Helena, Montana
Representing - Unemployment Compensation Commission
Occupation - Defense and Mobilization Coordinator

*Lloyd Johnson
Montana Probation, Parole and Correctional Association
Lewistown, Montana
Representing - Montana Probation, Parole and Correctional Association
Occupation - Probation Officer

**Mrs. Nelda Johnson
Box 1052
Denton, Montana
Representing - Chairman, District No. 6
Occupation - Housewife

Mrs. Howard Kenna
108 North Sixth Street
Livingston, Montana
Representing - Montana Speech and Hearing Association
Occupation - Housewife

Mrs. Virginia Kenyon
State Board of Health
Helena, Montana
Representing - State Board of Health - Public Health Nursing
Occupation - Registered Nurse

Carl F. Kraenzel, Ph.D.
Montana State College
Bozeman, Montana
Representing - Montana State College
Occupation - Rural Sociologist

*Mrs. Edna Kuhn
Montana Nurses Association
1250½ Harrison Avenue
Butte, Montana
Representing - State Board of Health - Mental Health Unit
Occupation - Registered Nurse

*Glenn Lockwood
Bureau of Vocational Rehabilitation
Power Block
Helena, Montana
Representing - Bureau of Vocational Rehabilitation
Occupation - Teacher

*Mrs. Barbara Longmaid
State Department of Public Instruction
State Capitol Building
Helena, Montana
Representing - State Superintendent of Public Instruction
Occupation - School Administrator

Senator William L. Mathers
P.O. Box 267
Miles City, Montana
Representing - Legislative Council
Occupation - Rancher

*Thomas McMasters
1109 Livingston Avenue
Helena, Montana
Representing - Montana Association for Retarded Children
Occupation - Dairy Technologist

**Richard G. Milne, ACSW
P.O. Box 1546
Great Falls, Montana
Representing - Chairman, District No. 7
Occupation - Social Worker

**The Reverend Walter J. Moris
1037 North Ewing
Helena, Montana
Representing - Chairman, District No. 8
Occupation - Minister

Richard F. Morris
Office of Budget Director
State Capitol Building
Helena, Montana
Representing - State Budget Director
Occupation - Accountant

Mrs. Walter Needham
Montana Association for Mental Health
116 Oak Street
Anaconda, Montana
Representing - Montana Association for Mental Health
Occupation - Mental Health Worker

Clyde Neu
Philipsburg, Montana
Representing - Montana County Commissioners Association
Occupation - Insurance Salesman

Dell Samson, Ph.D.
Montana State College
Bozeman, Montana
Representing - Montana State College
Occupation - Rural Sociologist

Mrs. Connie Simonsen
440 Evans
Missoula, Montana
Representing - Montana Speech and Hearing Association
Occupation - Housewife

Edward Stowe
City Hall
P.O. Box 1178
Billings, Montana
Representing - Montana Public Health Association
Occupation - Sanitarian

**John R. Taylor
1500 North 30th
Billings, Montana
Representing - Chairman, District No. 12
Occupation - Psychologist

W. G. Tobin, M.D.
Mental Hygiene Clinic
555 Fuller Avenue
Helena, Montana
Representing - Department of Mental Hygiene
Occupation - Psychiatrist

John G. Watkins, Ph.D.
Psychology Department
Montana State University
Missoula, Montana
Representing - Personal Interest
Occupation - Psychologist

Winfield S. Wilder, M.D.
Great Falls Clinic
1220 Central Avenue
Great Falls, Montana
Representing - Montana State Medical Association
Occupation - Psychiatrist

**Casper Wolhowe, ACSW
Industrial School
Miles City, Montana
Representing - Chairman, District No. 13
Occupation - Social Worker

* Steering Committee Members

** District Chairmen

CHRONOLOGY OUTLINE OF PLANNING ACTIVITY

| | Target Date for Completion |
|---|---|
| PHASE I | June 30, 1963 |
| Initial State Planning Committee Meeting | |
| PHASE II | October 16, 1963 |
| Montana State Plan for Utilization of Federal Planning Grant for a Mental Health Program Approved. | |
| Selection of a 12-Man Steering Committee From the State Planning Committee. This Committee to meet monthly. | |
| State Planning Committee to Meet at Least Each Quarter. | |
| PHASE III | January 15, 1964 |
| Selection of a Project Director and Staff Members | |
| PHASE IV | March 31, 1964 |
| Selection of a Steering Committee in Each District | |
| PHASE V | May 30, 1964 |
| Larger Committees Formed In Each District Including Membership From Individual Counties in the District | |
| PHASE VI | |
| Public Meeting Held in Each District | November 30, 1964 |
| Data Collection by Counties and Districts | November 30, 1964 |
| Data Collection by Public and Private Agencies | December 31, 1964 |

| | |
|---|---|
| PHASE VII | January 30, 1965 |
| Analysis of Data | |
| PHASE VIII | April 31, 1965 |
| Comprehensive State Mental Health Plan is Developed | |
| PHASE IX | July 30, 1965 |
| Adoption of State Plan | |

REPORT OF EXPENDITURES:

FISCAL 1964
ACTUAL EXPENDITURES
7-1-1963 TO 6-30-1964

| | |
|---|---|
| Salaries and Benefits . . . . . | $ 13,841.36 |
| Travel: | |
| Staff . . . . . | 3,031.33 |
| Committee . . . . . | 2,573.73 |
| Supplies . . . . . | 1,011.91 |
| Communications . . . . . | 526.65 |
| Contracted Services . . . . . | 700.28 |
| Repairs . . . . . | 1.75 |
| Capital . . . . . | 22,288.01 |
| TOTAL EXPENDITURES . . . . . | $43,975.02 |

REPORT OF EXPENDITURES AND ENCUMBRANCES:

FISCAL 1965
ACTUAL EXPENDITURES
7-1-1964 TO 4-30-1965

| | |
|---|---|
| Salaries and Benefits | $ 23,863.01 |
| Travel: | |
| Staff | 2,005.67 |
| Committee | 3,303.62 |
| Supplies | 916.42 |
| Communications | 877.72 |
| Contracted Services | 1,127.30 |
| Capital | 34.45 |
| TOTAL EXPENDITURES | $32,128.19 |

FISCAL 1965
PROJECTED EXPENDITURES
5-1-1965 TO 6-30-1965

| | |
|---|---|
| Salaries and Benefits | $ 7,549.19 |
| Travel: | |
| Staff | 400.00 |
| Committee | 900.00 |
| Supplies | 900.00 |
| Communications | 1,000.00 |
| Contracted Services | 315.00 |
| Capital | 50.00 |
| Other | 150.00 |
| Printing Costs | 4,000.00 |
| TOTAL PROJECTED EXPENDITURES | $15,264.19 |
| TOTAL EXPENDITURES | $47,392.38 |

PROJECT OFFICE

MONTANA MENTAL HEALTH PLANNING COMMITTEE

PROFESSIONAL STAFF

| | | Employment Dates From | To |
|---|---|---|---|
| John G. Thomas, ACSW<br>Masters Degree - Social Work | Project Director | 12-1-63 | 6-30-65 |
| Thomas L. Gooch<br>Masters Candidate - Public Administration | Research Assistant | 1-6-64 | 6-30-65 |
| Kay Turner | Secretary | 12-12-63 | 6-30-65 |
| Ann Bossell | Statistical Clerk | 9-14-64 | 6-30-65 |

NOTE: All of the above employees spent 100 percent of their time on the Project.

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N

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